OUR PEOPLE. OUR HEALTH.

PLANNING ERIE ST. CLAIR'S FIRST LOCALLY FOCUSED HEALTH CARE SYSTEM

IHSP

INTEGRATED HEALTH
SERVICE PLAN

THE PLAN

ERIE ST. CLAIR'S INTEGRATED HEALTH SERVICE PLAN

ERIE ST. CLAIR LOCAL HEALTH INTEGRATION NETWORK

INTEGRATED HEALTH SERVICE PLAN

October, 2006

Acknowledgements

The Erie St. Clair Local Health Integration Network (LHIN) team thanks everyone who helped develop this Integrated Health Service Plan. We are grateful to everyone who attended and participated in the community roundtable sessions, presentations, meetings and surveys throughout our region over the past seven months. We would also like to acknowledge the valuable input and feedback received from people who served on the Erie St. Clair LHIN's Steering, Geographic, Decision Support, e Health and Wait Time Committees, along with colleagues within the Ministry of Health and Long Term Care and the staff of other LHINs for sharing their perspectives with us. We are pleased to forward a plan which provides an overview of health services and needs within our LHIN. It is our intention that this plan captures and expresses the thoughts and feelings of local citizens and health care providers. While the scope of the plan encompasses a region where over 651,000 people live and outlines multiple local strategic directions for change in the future, the intention of this plan is simple: to help improve health care for the citizens of the Erie St. Clair LHIN.

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A note about the images featured in this document:

This document provides a detailed statistical overview of the health care issues that define the Erie St. Clair LHIN as a distinct service area. The images featured on the cover and on the section markers were chosen to provide a partial glimpse of the people, places and lifestyles behind the numbers.

Special thanks to those who generously contributed their photographic work, including:
The Convention & Visitors Bureau of Windsor, Essex County and Pelee Island
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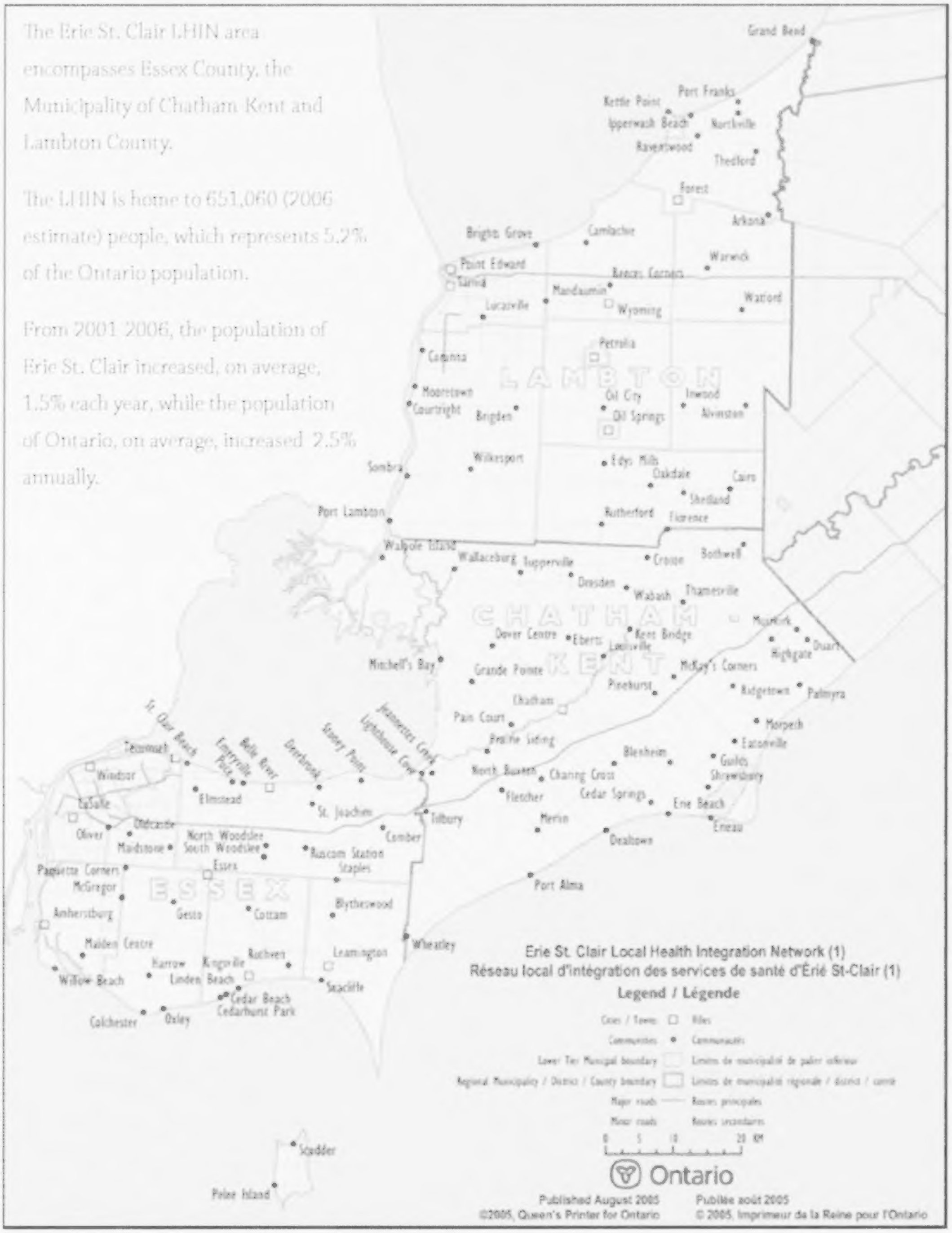
Richard Armstrong

The Erie St. Clair LHIN area encompasses Essex County, the Municipality of Chatham-Kent and Lambton County.

The LHIN is home to 651,060 (2006 estimate) people, which represents 5.2% of the Ontario population.

From 2001-2006, the population of Erie St. Clair increased, on average, 1.5% each year, while the population of Ontario, on average, increased 2.5% annually.


Grand Bend
Kettle Point
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Northville
Ravenswood
Thedford
Forest
Arkona
Brights Grove
Camlachie
Point Edward
Sarnia
Warwick
Reeces Corners
Mandaumin
Lucasville
Wyoming
Watford
Petrolia
Corunna
LAMBTON
Mooretown
Courtright
Oil City
Inwood
Brigden
Oil Springs
Alvinston
Sombra
Wilkesport
Edys Mills
Oakdale
Cairo
Shetland
Port Lambton
Rutherford
Florence
Walpole Island
Wallaceburg
Tupperville
Croton
Bothwell
Dresden
Wabash
Thamesville
CHATHAM-KENT
Dover Centre
Eberts
Kent Bridge
Louisville
Muirkirk
Duart
Highgate
Mitchell's Bay
Grande Pointe
McKay's Corners
Pinehurst
Ridgetown
Palmyra
Chatham
Pain Court
Morpeth
Prairie Siding
Jeannettes Creek
Lighthouse Cove
Eatonville
St. Clair Beach
Tecumseh
Emeryville
Puce
Belle River
Deerbrook
Stoney Point
Blenheim
Guilds
Shrewsbury
Windsor
Elmstead
North Buxton
Charing Cross
Fletcher
Cedar Springs
Erie Beach
LaSalle
St. Joachim
Tilbury
Merlin
Erieau
Oldcastle
Oliver
Maidstone
North Woodslee
South Woodslee
Comber
Ruscom Station
Essex
Staples
Deaftown
Paquette Corners
McGregor
Port Alma
ESSEX
Amherstburg
Gesto
Cottam
Blytheswood
Maiden Centre
Harrow
Kingsville
Ruthven
Leamington
Wheatley
Willow Beach
Linden Beach
Seacliffe
Cedar Beach
Cedarhurst Park
Colchester
Oxley
Scudder
Pelee Island
Erie St. Clair Local Health Integration Network (1)
Réseau local d'intégration des services de santé d'Érié St-Clair (1)
Legend / Légende
Cities / Towns □ Villes
Communities ● Communautés
Lower Tier Municipal boundary Limites de municipalité de palier inférieur
Regional Municipality / District / County boundary Limites de municipalité régionale / district / comté
Major roads Routes principales
Minor roads Routes secondaires
0 5 10 20 KM
Ontario
Published August 2005
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Introduction

This plan is driven by the decision of the Ministry of Health and Long Term Care (MOHLTC) to make fundamental changes to the health care system in Ontario. The ministry recognizes that healthcare across the province needs to become more patient focused, results driven, integrated and sustainable. By establishing the Erie St. Clair Local Health Integration Network (LHIN), the province has given us the responsibility for local health transformation.

We will transform the local health care system by communicating with the community in several ways: local planning, coordination, integration, and delivery of key publicly funded health services.

Our Integrated Health Service Plan (IHSP) articulates eight strategic integration directions for the next three years. The purpose of this plan is to improve local health care outcomes for the citizens of our LHIN by offering opportunities for changes which will enhance health care delivery through the better integration of service planning.

Engagement and consultation with our local communities, health service providers and health service agencies played an important role in determining and confirming the strategic integration directions. In addition, we have made a determined effort to collect and analyze the most recent supporting population health and health planning data. We will continue to seek input about local health care needs through community consultation efforts and data analysis as we refine the Integrated Health Service Plan on an annual basis.

1.0 Provincial Context

1.1 Establishing Local Health Integration Networks in Ontario

The Local Health System Integration Act 2006 was passed March 1, 2006. The Act empowers the LHINs to partner with the Ministry to improve the health of Ontarians through better access to health services, more coordinated care, effective and efficient management at the local level. This legislation gives the 14 Local Health Integration Networks in the province the power to plan, integrate and fund local health services – including hospitals, Community Care Access Centres, Community Health Centres, as well as home care, long term care, mental health, addictions, community support services and other health care providers that currently receive funding from the Ministry.

1.2 The Role of Local Health Integration Networks

Learning from, and building on the experiences of other jurisdictions, Ontario developed a distinct "Made in Ontario" model of localized health system management. LHINs in Ontario differ from regional health authorities in other provinces in the following ways:

- LHIN borders, which are boundary-less for patients, do not limit patient choice of physician and medical or acute services
- LHINs are not providers of direct services
- LHINs do not require consolidation of existing health organizations' governance structures (e.g. hospitals and long term care homes will keep their own boards)

1.3 Provincial Vision for Health and Health care

Local Health Integration Networks share the provincial government's vision:

A health care system that helps people stay healthy, delivers good care to them when they get sick and will be there for their children and grandchildren.

The province foresees a system where providers speak to one another in the same language, where there are no longer impenetrable and artificial walls between stakeholders and services; a system driven by the needs of the patient and not the providers.

1.4 Key Provincial Principles

The provincial principles guiding the LHIN's mandate and responsibilities reflect health care reform that ensures:

- Equitable access based on patient need
- Preservation of patient's choice
- Measurable, results-driven outcomes based on strategic policy formulation, business planning and information management
- People-centred, community-focused quality care responding to local population health needs
- Shared accountability among providers, government, community and citizens

1.5 Key Provincial Strategies

Reducing wait times

- An immediate focus on decreasing wait times for key procedures and tests including cardiac procedures, cancer treatments, hip and knee joint replacement, cataract surgery, MRI and CT scans

Improved access to health professionals

- The creation of family health teams and increasing the supply and retention of health care professionals

Making Ontarians healthier by shifting from illness care to health care

- The promotion of healthy lifestyles, enhancing community based care and public health

Enabling coordination and integration

- LHINs are the first step toward a system that examines and prioritizes local health needs, eliminates barriers to access and ensures appropriate quality care

Using information to serve the needs of patients

- A focus on an integrated information management strategy that protects patient privacy and places health care information in the hands of those who need it to improve services and enhance decision-making for the patient

Enhanced accountability for health outcomes

- The Ontario Health Quality Council has been established to provide independent reporting of the results of changes in health care and bring accountability to the system

2.0 Vision for Health care in the Erie St. Clair LHIN

The Erie St. Clair LHIN is aligned with the provincial vision - A health care system that helps people stay healthy, delivers good care to them when they get sick, and will be there for their children and grandchildren.

We will work with our partners to achieve a local health care system that incorporates the following patient centred themes:

- Accessibility - Improving timely access to care and services
- Integration - Promoting a system perspective through improved LHIN wide coordination and planning
- High Quality - Improving quality through best practices, monitoring and coaching efforts
- Sustainability -Ensuring effective and efficient use of resources and by maintaining the gains achieved

This IHSP was developed to be consistent with the vision and strategic directions of the Ministry of Health and Long-Term Care (MOHLTC).

2.1 *Key Local Realities Impacting the Erie St. Clair LHIN*

Several key preliminary issues were identified as we explored characteristics, trends and barriers that would impact implementation of the local vision. Key realities and observations from the initial consultation with stakeholders and providers are listed below.

2.1.1 *Population Demographics*

The Erie St. Clair LHIN population is older than the Ontario average. Between 2006 and 2016:

- Chatham-Kent's population is projected to decline 1%
- Lambton's population is projected to increase 1%
- Essex's population is projected to grow 12%

Essex is the fastest growing area outside the Greater Toronto Area. These projections will have an impact on health services planning and resource allocation.

2.1.2 *Burden of Illness*

Circulatory disease and higher incidence of arthritis and rheumatism contributes to the burden of illness within the Erie St. Clair LHIN. This finding has a unique impact on health care resource utilization and planning.

2.1.3 *Transportation*

Non-emergent ambulance transportation, transportation for seniors, rural transportation and timely delivery of patients to service providers, are among the key concerns expressed to us regarding the health care system's operation. Gaps in transportation impact on efficiency and effectiveness of care delivery for both the service provider and the patient.

2.1.4 *Health Human Resources*

A shortage of physicians and other health care professionals, and the aging of existing health care professionals, contribute to a decrease in services for citizens. The migration of younger health care professionals to nearby Michigan (United States) health care centres is also a factor.

2.1.5 *Capacity Issues*

Hospitals in Sarnia and Windsor are still undergoing construction, resulting in an inefficient operation of the facilities and impacting patient services. A recent decrease in available Long Term Care beds in the Erie St. Clair LHIN is putting pressure on Alternate Level of Care (ALC) patients (patients who do not require acute services) found in acute care hospital beds in the region. These bed capacity pressures cause backups in the Emergency Departments, increase wait times and cancel some surgeries.

2.1.6 *Access Concerns*

Lambton County and Chatham-Kent health care providers and citizens have established referral patterns predominantly with Middlesex County hospitals – notably with the London Health Sciences Centre. Citizens have expressed a strong preference to maintain the east to west referral pattern for services such as tertiary care. Sarnia/Lambton citizens expressed strong concern regarding the direction of patient care from Sarnia/Lambton to the Windsor/Essex area by the Erie St. Clair LHIN.

2.2 *Integration Strategy*

We will be a catalyst for change within the Essex, Lambton and Municipality of Chatham-Kent planning area. Integration strategies must be aligned with the vision of the Erie St. Clair LHIN, with the principles that guide LHIN activities and with the current key local realities as outlined in section 2.1.

The following is a brief listing of the strategic outcomes that the LHIN strives to achieve.

- Improved access to the care and services needed by the LHIN communities

- Improved service quality through best practice, monitoring, and coaching efforts
- Improved sustainability by ensuring effective and efficient use of resources and the maintenance of the gains achieved
- Consistently promote a system perspective in all decision-making

Below is a brief listing of the tactics that we will use to achieve the above desired outcomes:

- Enhance existing partnerships and best practices, including those from across the province
- Build new partnerships linking health care providers with a shared mission and synergistic functions
- Promote and facilitate opportunities for integration and system improvement from provider and citizen perspectives
- Identify horizontal and vertical clinical integration opportunities
- Develop or enhance networks for increased communication, information exchange, training opportunities and joint accountability perspectives

2.3 Guiding Principles for Decision Making

The following are the guiding principles used in evaluating Erie St. Clair LHIN integration decisions. We must strive to:

- Eliminate or reduce barriers to access
- Commit to service equity, innovation and diversity
- Play a role in the education of future health care professionals, establishing best practice standards, generating new health knowledge and developing technological innovation
- Address the critical mass needed to ensure clinical competence
- Be evidence based
- Address the continuum of care and contribute to improved continuity of care
- Address the health service needs of the population in the catchment area (as identified by demand, utilization rates, waiting lists, population health and epidemiological data)
- Build on existing relationships and reflect the existing formal agreements and commitments with other organizations in coordinating delivery of health care services
- Enhance service quality and efficient use of resources in the health care system through coordination and collaboration among services
- Review feasibility of new or enhanced services within existing financial and human resource constraint realities

2.4 Erie St. Clair LHIN Strategic Integration Direction Alignment with Ministry of Health and Long-Term Care (MOHLTC)

Erie St. Clair LHIN Strategic Integration Directions for Local Health care

Provincial Priorities	Chronic Disease Management	System Navigation	Health Promotion and Illness Prevention	Timely access to appropriate care and services	Reduce Dependence on Hospital-based Services	Back office/ Administrative Integration	Health Human Resources	Supporting People At Home
Reducing wait times				✓	✓		✓	✓
Improved access to health professionals		✓		✓	✓		✓	✓
Making Ontarians healthier by shifting from illness care to health care	✓		✓		✓			
Enabling Coordination and integration	✓	✓	✓	✓	✓	✓	✓	✓
Using information to serve the needs of patients	✓	✓		✓		✓		✓
Enhanced accountability for health outcomes	✓				✓	✓		

3.0 Key Findings from the Environmental Scan

The following are the key findings from the environmental scan that have informed and guided the strategic directions for change. The full environmental scan, the findings of community engagement and stakeholder consultation processes are contained within the appendices of the report.

3.1 *Population Health and other Significant Characteristics*

Age

Overall, the population of the Erie St. Clair LHIN is older than the Ontario provincial average, specifically in the 85+ cohort. Chatham-Kent and Lambton have fewer 15 to 44 year-olds and more persons aged 65 and older.

Based on population growth projections the Erie St. Clair LHIN should plan for:

- A 5% reduction in population-based demand for 0 – 44 year olds
- A 16% increase in services for 45 to 64 year-olds
- A 28% increase for 65+ year olds for the next 10 years

Education

In addition to being a determinant of health, education levels are critical in the design of education and instructional material and in mechanisms to ensure community engagement. The percentage of the Erie St. Clair population without a high school diploma is significantly higher than Ontario with the Municipality of Chatham-Kent considerably higher within our LHIN.

Ethnicity

Erie St. Clair LHIN residents tend to come from more multiple ethnic origins as compared to Ontario as a whole.

Aboriginal population

The percentage of Aboriginal people in the Erie St. Clair LHIN is higher than in the province overall. Of the number of persons who self report aboriginal identity, 2.54 times as many in Lambton County consider themselves aboriginal as compared to Ontario overall. Canadian studies of First Nations health care consistently show that First Nations populations have reduced life expectancy and poorer health status than the general Canadian population.

Socio-economic status

Low-income respondents are more likely to have reported their health as fair or poor. In terms of average income, Chatham-Kent and Lambton County incomes are significantly lower than Ontario, while Essex

County is significantly higher. The number of Erie St. Clair LHIN residents who receive their income from government transfers (e.g. Old Age Security, EI, CPP), is 1.12 times greater than the Ontario average, but rates are 1.34 and 1.28 times higher in Chatham Kent and Lambton as compared to the province.

Growth rate

Essex has a growth rate of 9.3% for 2001 to 2006. The provincial growth rate for the same period is 11.3%. This rate of growth is expected to continue but may be impacted by economic factors.

Health perceptions

Residents in the Essex and Lambton areas within the Erie St. Clair LHIN were more likely to report that they had unmet health care needs relative to Ontario.

Burden of illness

The burden of illness data have demonstrated an impact on the Erie St Clair LHIN. All circulatory disease mortality rates are significantly higher across the LHIN for both males and females in comparison to the province. Of note, deaths from ischemic heart disease circulatory and cerebrovascular disease are all higher than the Ontario average. The incidence of cancer is also significantly higher for the Erie St. Clair LHIN than that of Ontario. Potential Years of Life Lost (PYLL), another key indicator demonstrating burden of illness, indicates that cancer, circulatory disease, ischemic heart disease, cerebrovascular disease, respiratory disease, pneumonia and influenza deaths and unintentional injury deaths, are higher than the Ontario average.

Finally, for Erie St. Clair LHIN residents: (compared to Ontario)

- 1.23 times more have arthritis and rheumatism
- 1.13 times more have asthma
- 1.06 times more have diabetes
- 1.15 times more have high blood pressure

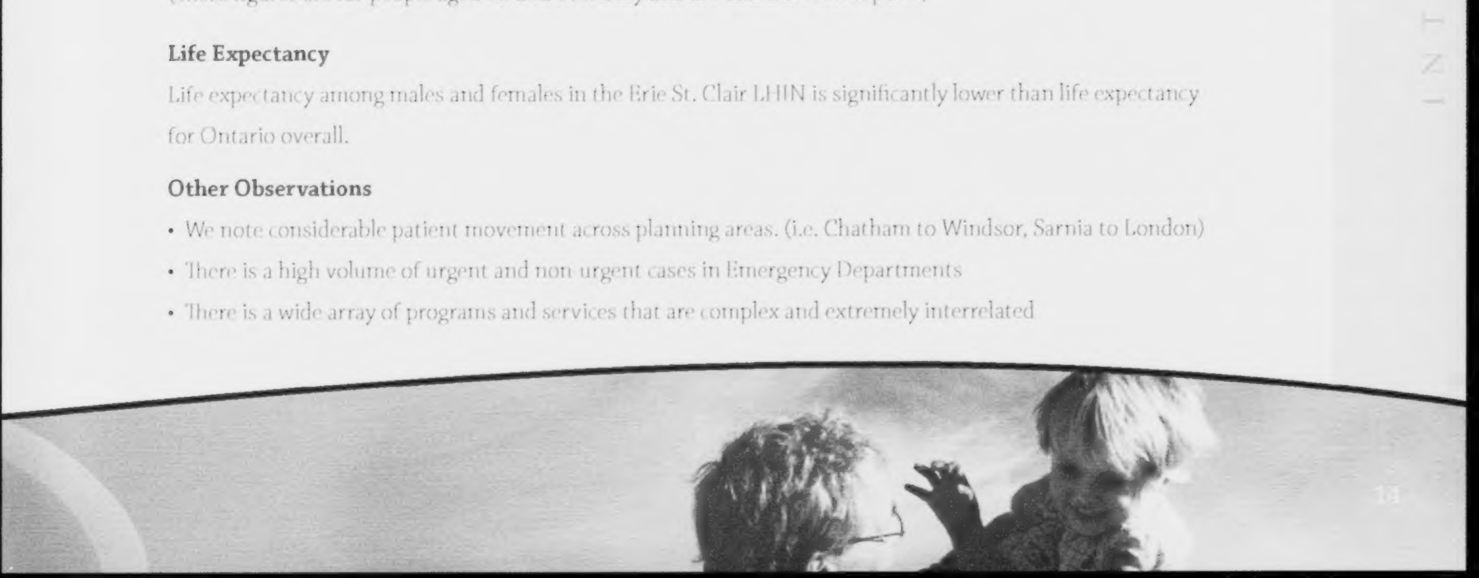
(These figures are for people aged 12 and over only and are based on self-reports)

Life Expectancy

Life expectancy among males and females in the Erie St. Clair LHIN is significantly lower than life expectancy for Ontario overall.

Other Observations

- We note considerable patient movement across planning areas. (i.e. Chatham to Windsor, Sarnia to London)
- There is a high volume of urgent and non-urgent cases in Emergency Departments
- There is a wide array of programs and services that are complex and extremely interrelated



3.2 *Health Services Utilization*

Over 130 health service providers, funded by the Ministry of Health and Long Term Care, are available locally to the Erie St. Clair LHIN residents throughout the local continuum of care. Currently, in 2006, there are 1,370 hospital beds (on average) staffed and in operation across the Erie St. Clair LHIN.

Hospital beds

There are 861 acute beds of which,

- 44% are medical beds
- 21% are surgical beds
- 12% are combined medical/surgical beds
- 10% are critical care/intensive care beds
- 6% are paediatric
- 7% are obstetric

The Erie St. Clair LHIN has in service

- 128 mental health beds
- 256 complex continuing care beds
- 125 rehabilitation beds

The projected total hospital bed capacity available for 2006/2007 is 1,511 – consisting of 924 acute beds, 136 mental health beds, 321 complex continuing care beds and 130 rehabilitation beds.

Localization Index

Erie St. Clair Hospitals provided treatment to 85% of Erie St. Clair LHIN acute inpatients, with the Southwest LHIN (12.5%) being the next most common location for overall hospitalizations. The age standardized separation rate for all levels of care within the Erie St. Clair LHIN is significantly higher than for Ontario residents.

Mental Health

Acute mental health visits represented 7.7% of all separations and 15.4% of total days for Erie St. Clair hospitals – higher proportions than those for Ontario Hospitals (5.8% and 10.9% respectively). The age standardized mental health separation rate for Erie St. Clair residents was significantly higher by 35% than the rate for Ontario residents.

Rehabilitation

Rehabilitation days have remained consistent within the Erie St. Clair LHIN over the most recent three-year period. Utilization data are summarized in the following chart:

Year	2003/2004	2004/2005	2005/2006
Patient days	40,450	40,277	40,500

The Erie St. Clair LHIN generated an average length of stay of 17.7 days for rehabilitation in 2005/2006 and accounts for 5% of the total provincial rehabilitation days.

In 2005/2006 there was a monthly average of 153 individuals admitted for Long Term Care placement, ranging from 130 to 176 per month. There was also a monthly average of 1,222 awaiting admission to long term placement, ranging from 964 to 1,336 per month.

Health Professionals

Although the limitations of the data are acknowledged, the Erie St. Clair LHIN has fewer health care professionals per 100,000 population than Ontario in all categories, with the exception of Extended Class Registered Nurses and Registered Practical Nurses. Efforts will be made in future years to obtain standardized Health Human Resource data for planning purposes.

3.3 Health System Strategy Score Card

A Local Health System Strategy Scorecard using a strategy-based approach was developed to establish performance improvement measures for the provincial health care system. This strategy based approach yielded four key dimensions of performance - Knowledge Utilization & Dissemination; Integrated Care; Health Status & Outcomes; and Health System Sustainability and Equity.

In review of the Health System Strategy Scorecard results for all provincial LHINS, the Erie St. Clair LHIN has identified local indicators requiring further attention as we move forward with plans for the local health care system:

- Congestive heart failure care
- Emergency department visits that could be managed elsewhere
- Skin ulcer care in residential settings
- Cancer deaths in acute care beds
- Hospitalization rate for ambulatory care sensitive conditions

- Unmet service needs
- Inpatient rehabilitation effectiveness
- Acute myocardial infarction care
- Readmission for neonatal events
- Potential years of Life Lost for respiratory disease and suicide
- The limited number of non-specialists providing care in the Erie St. Clair LHIN

3.4 *Community Engagement Findings*

Community engagement for the Erie St. Clair LHIN is guided by "Healthcare Matters," a framework document widely distributed and subjected to public and stakeholder feedback. "Healthcare Matters" provided the strategic backdrop for how the Erie St. Clair LHIN pursued our engagement activities.

Our leadership team and planning staff interacted with the community through engagement forums (round tables). To date, 19 sessions, attracting approximately 500 citizens and health care service providers, were held throughout the Erie St. Clair LHIN.

The issues developed through the consultation process included:

1. The training, recruitment and retention of health professionals (including physicians)
2. Increased access and improved wait times
3. Increased emphasis on health promotion and disease prevention
4. Improved health system navigation and continuity of care
5. Issues related to mental health continuum of care
6. Increased involvement and participation of Francophone, other minority groups and rural groups throughout the system's services process
7. Improved information and data regarding the needs and the health status of various unique communities within the Erie St. Clair LHIN
8. The need for a comprehensive, robust Electronic Health Record
9. Focus on primary care
10. Shift from provider- to patient focus
11. Transportation
12. Need for a long term transparent, sustainable, financial plan
13. Increased availability and support for advanced technology and therapeutic measures
14. Development of best practice guidelines, quality measures, and related accountability
15. Issues related to non-acute bedded services
16. Confidentiality

A comprehensive list of comments received from participants in community round table sessions regarding priority issues by county are found in Appendix D.

3.5 Readiness Assessments

3.5.1 LHIN e-Health Strategy

The Erie St. Clair LHIN has established an e-Health strategy planning process to implement LHIN-wide initiatives.

The e-Health strategy is aligned across the following strategic directions:

1. Improve provider efficiency through information sharing and integration of services
2. Improve management and prevention of chronic diseases
3. Empower clients
4. Improve operational efficiency

Using a process that included interviewing stakeholders from across the health care sectors and local LHIN Executives, reviewing strategic documents and generating an Information management/Information Technology survey that identified information gaps, a "Clinical and Business Needs" document was developed. The following list is a summary of those needs. The elements of the list are ranked in importance from high need to low need in terms of relative priorities.

1. Information sharing across the organization and sector
2. Improving connectivity and infrastructure
3. Supporting business intelligence and strategic decision making
4. Improving operating efficiency
5. Improving communication
6. Engaging clients/citizens
7. Focusing on staff education, retention and restructuring

Current work of the e-Health strategy focuses on developing a three-year implementation roadmap, the costing of the strategy initiatives, and the development of an accountability mechanism through a Memorandum of Understanding.

3.5.2 *Wait Times*

In 2004 the Ministry of Health and Long Term Care introduced a wait time strategy as part of its health transformation agenda. As of July 2006 the wait time results show that Erie St. Clair LHIN hospitals met the provincial wait time targets for three of the priority areas: cancer surgery, cataract surgery and cardiac angiography. The hospitals did not meet the wait time targets for three areas: hip and knee joint replacements, magnetic resonance imaging (MRI) and computerized tomography (CT) scans. On September. 12, 2006, the Ministry announced further funding for an additional 6,745 MRI and CT scans to assist Erie St. Clair residents in accessing these procedures. None of the service providers within the Erie St. Clair LHIN provide cardiac angioplasty or cardiac bypass surgery at this time. The data for Southwest LHIN is shown as the best proxy for Erie St. Clair LHIN wait times.

Readiness activities include the development of an Erie St. Clair Wait Times Steering Committee, which will develop strategies and plans to work towards meeting or exceeding the targets within the Ontario Wait Time Strategy. The steering committee has representation from all of the hospitals within the Erie St. Clair LHIN, the Community Care Access Centre, medical staff leadership and the Rehabilitation Network. The committee is currently working on the following initiatives:

Medical Staff Involvement and Input

- Meeting with the Chiefs of Staff, Chiefs of Surgery, Anaesthesiologists, Ophthalmologists and Orthopedic Surgeons to discuss possible wait time strategy opportunities and to share best practices from across the province.

Best Practices

- The Committee is looking at projects and processes that have already been funded by the Wait Time Team and are perceived as best practices, with possible application for LHIN

Coaching Teams

- The Committee will also work with the Wait Time Team from the ministry to streamline surgical processes and improve data collection for indicator development and benchmarking

These initiatives will be ongoing over the next three years. Our Steering Committee will develop expert task forces to work on specific projects. The work of the Steering Committee will be reported to the Erie St. Clair LHIN Board of Directors on a bi annual basis.

4.0 Erie St. Clair LHIN Strategic Integration Directions for Change

We have identified eight strategic Integration directions for local health care change through a process that incorporated information from a variety of sources including community consultation, data analysis, provincial goals and objectives and prior planning reports. The following sections define and provide general insight into the key drivers supporting each direction.

4.1 Chronic Disease Management

Chronic disease management (diseases for which there is no cure, but that can be managed) is a pro-active, population-based approach that addresses chronic diseases early in the disease cycle to prevent disease progression and reduce potential health complications.

Multiple strategies are used to improve the health of all patients diagnosed with specific conditions. This approach reduces the need for acute interventions in the future and allows people to maintain their independence and health status for as long as possible. Chronic disease management involves all components of the service continuum and requires integrated strategies based on common principles and protocols. These strategies need to differentiate the roles of agencies and practitioners to produce a coordinated and effective system for the management of chronic diseases.

The Erie St. Clair LHIN planning process supported this directive in its examination of population and hospital utilization data.

4.2 Reduce Dependence on Hospital Based Services

Hospital-based services are often the most complex and expensive in the system. Sometimes, hospitals provide services, particularly emergency services, because patients often spend too much time in hospital beds because non-hospital services are not available or the patient must wait for services to become available. Integrated strategies are required to continuously monitor and identify opportunities to reduce the strain on hospital services by providing community-based care alternatives when appropriate.

The Erie St. Clair LHIN planning process supported this directive in its examination of population and hospital utilization data. Community consultation also identified this direction as an opportunity for health system improvement.

4.3 Supporting People at Home

Programs and services that assist people to remain at home longer or allow patients to leave provider-based

services sooner, will relieve pressure on and demand for institutional care. These services can also improve the effectiveness of family and community supports, as well as the health and quality of life of individuals.

Community consultation within the Erie St. Clair LHIN strongly identified this direction as an opportunity for health system improvement as does the analysis of local health system utilization. In coming months, we intend to achieve greater understanding of the unique services provided in the planning region in order to implement this direction.

4.4 *Back Office/Administrative Integration*

Striving for increased administrative efficiencies places more resources in the hands of service providers and, subsequently, into enhanced services. The LHIN e-Health strategy is developed by system partners as a tactic for improving back office functions and administration. These efficiencies improve client care and safety, and empower clients/public/providers.

This local direction is directly aligned with Ontario's Health Care Transformation Agenda.

4.5 *System Navigation*

The health care system can be complex and confusing, making it difficult for patients and families to access appropriate services. Patients often need assistance navigating their way through the system in order to access the right service at the right time. System navigation and coordination and integration of care across the cancer continuum have also been flagged as a priority for action in developing the regional cancer system for Erie St. Clair.

Shared information systems, standard protocols, patient and provider education, streamlined referral systems and navigation resources will all contribute to improved, timely access to appropriate services and a more efficient movement of patients through the system.

The Erie St. Clair LHIN planning process supported this directive in response to community consultation feedback provided in community forums and subsequent polling.

4.6 *Health Human Resources*

Many communities and health service agencies experience difficulty recruiting and retaining qualified health care professionals. They often compete for scarce resources such as GPs, NPs, nurses and many other health professionals who are in short supply. Recruitment and retention of health care professionals can be improved through the implementation of strategies that develop a health care system that properly supports health care professionals in a positive and progressive practice environment.

Community consultation within the Erie St. Clair LHIN strongly identified this direction as an opportunity for health system improvement. We intend to partner with local and provincial initiatives in order to address this need.

4.7 *Health Promotion and Illness Prevention*

Health promotion is the process of encouraging people to make healthy lifestyle choices and motivating them to accept greater responsibility for maintaining their health. To achieve this, health promotion strategies in primary practice focus on patient education, counselling and support tools that promote physical activity, improve nutrition or reduce the use of tobacco, alcohol or drugs.

Disease or illness prevention focuses on prevention strategies that reduce the risk of disease, identify risk factors, or detect disease in its early, most treatable stages. Examples of disease prevention activities include well-baby visits, immunizations, calcium and Vitamin D supplements to reduce the risk of osteoporosis, blood pressure and cholesterol assessments during annual health exams, and screening for illnesses such as breast, cervical, colorectal and prostate cancer.

All health care agencies and practitioners have a role in health promotion and illness prevention. Integration strategies that clearly define the various complementary roles and activities are required, based on common principles and information. Effective implementation of these strategies will reduce the disease and illness burden and contribute to improving health status. Health promotion and illness prevention have been highlighted as priorities for action within the cancer plan for the Erie St. Clair LHIN and in the Cancer 2020 Plan for Ontario.

The Erie St. Clair LHIN planning process supported this directive in its examination of population health data and through community consultation activities. We will partner with public health agencies to achieve public health objectives related to this direction.

4.8 *Timely Access to Appropriate Care and Services*

Timely access to quality health services is a fundamental principle for the establishment and sustainability of an effective and efficient health care system. Services need to be available when people need them. Current access issues exist because of a shortage of primary care, excessive wait times for specialty care, a lack of transportation to and from non-urgent care, availability of some testing and screening services, and a need for improved transitions through the health care system. We will assist our partners in identifying strategies where access can be improved.

Community consultation within the Erie St. Clair LHIN strongly identified this direction as an opportunity for health system improvement. This direction is also clearly aligned with provincial strategies.

5.0 Current Activities: Summary of Achievements

Since its inception, the Erie St. Clair (LHIN) has participated in over 400 meetings, presentations, forums, and provider board meetings. More than 2,000 people have been engaged in this process to create awareness and introduce the Erie St. Clair LHIN mandate.

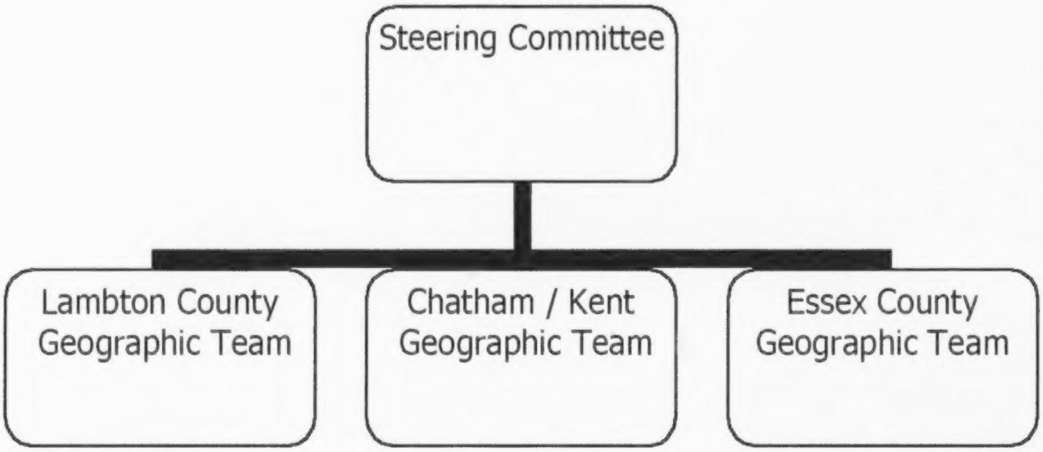
In the fall of 2004, the Ministry of Health and Long Term Care asked a committee of local health and community leaders to report on local health care "priority issues." The Erie St. Clair LHIN has used these priority issues in its community engagement opportunities.

5.1 Steering Committee and Geographic Team for the IHSP

An IHSP Steering Committee was developed to oversee the planning process and give insight into local issues. The Steering Committee is supported by three teams that provide input and advice on local priorities from the Municipality of Chatham-Kent, Essex County and Lambton County.

The Steering Committee and Geographic Teams includes local health care providers, physicians, community members and board members of the Erie St. Clair LHIN. Their role includes assisting LHIN staff in the collection and dissemination of information, engaging members of the community, enhancing the knowledge of the health care system, providing guidance on intra-LHIN issues, and ultimately shaping the IHSP.

Please see Appendix F for further information on the Steering Committee and Geographic Team members and the decision-making process for the Integrated Health Service Plan.


Steering Committee
Lambton County Geographic Team
Chatham / Kent Geographic Team
Essex County Geographic Team

5.2 *Decision Support Team*

A team of data management leaders representing all Erie St. Clair LHIN hospitals and Community Care Access Centres (CCACs) agreed to serve as a Decision Support Team to assist us with collecting data and providing input on data quality issues related to the development of the IHSP. The Decision Support Team helped identify emerging trends and major issues impacting on local health care delivery in their organizations from a data management perspective. In the future, the Erie St. Clair LHIN anticipates broadening the scope of representation on the Decision Support Team to add the valuable input of data collection specialists from community agencies and public health units within our area.

Please see Appendix F for further information on the Decision Support Team members and contributions to the Integrated Health Service Plan.

5.3 *Community Engagement Forums (Round Tables)*

The Erie St. Clair LHIN held community engagement forums (Round Table meetings) with the following objectives:

- Engaging with the public in their communities
- Informing and educating the community about the IHSP process
- Providing an overview of the overall population health of Erie St Clair residents
- Reviewing the previously mentioned priority report in order to determine if the previously articulated priorities (from 2004) are still valid
- Listening to issues and priorities from a community perspective

These open Round Table engagement sessions were also attended by health service providers, media and, in some cases, Family Health Teams and Community Health Centre leaders. Members of the Erie St. Clair LHIN staff were available to answer questions one-to-one. The sessions were held in advertised locations throughout our LHIN.

To summarize

- Four sessions were held in Lambton County with total attendance of 139
- Four sessions were held in the Municipality of Chatham-Kent with total attendance of 106
- Five sessions were held in Essex County with a total attendance of 147
- Two French language sessions were also held, one in Windsor and one in Pain Court with total attendance of 54 between the two sites
- One session was held at the Downtown Mission for the homeless in Windsor with a total attendance of 25
- One session was held at the Windsor Teen Health Centre with a total attendance of 14

- The total attendance for all round table community engagements was 485 participants

5.4 *Aboriginal Community Engagement*

Learning about the health needs and priorities of the First Nations is a key priority for the Erie St. Clair team's development of the Integrated Health Service Plan. We are still in the process of working with Aboriginal and Métis communities to develop engagement strategies; however, we are gaining a better understanding of the perspective some Aboriginal groups have regarding cooperation and interaction with the Local Health Integration Networks.

5.5 *Informal Citizen Street Poll*

A further major phase of the community engagement process was the "Feet on the Street" initiative. An informal poll was developed based on key themes from the Round Table engagement sessions. During the summer months, 10 temporary employees throughout the Erie St. Clair LHIN used surveys to engage citizens on health care issue discussions. The project reached approximately 7,500 Erie St. Clair LHIN citizens.

Informal Citizen Street Poll Results: Health Care Priorities (Summer 2006)

Responses (from 5,477 surveys)	ESC (%)
Decrease wait times for health care	84
Keep family physicians, specialists and other health care providers	75
Get access to care in your local community	44
Improving the mental health care system	24
Health record accessible by all health care providers	22
Transportation to health care services	21
Increased attention to health promotion/prevention	20
Help with information/navigation through the system	12

These findings will be analyzed to further assist in the development of the Erie St. Clair LHINs strategic directions and actions.

Please see Appendix D for the initial analysis of the Feet on the Street informal poll.

5.6 *Activities Accomplished*

One of our main objectives has been to form strong relationships with communities and health care providers. We continue to listen to their views and issues. The Erie St. Clair LHIN activities have included:

- Establishing governance processes and policies

- Developing relationships
- Recruiting staff
- Developing and implementing business processes
- Facilitating local Family Health Teams and Community Health Centre proposals
- Building reliable and valid evidence based data sources
- Developing a Wait Time Strategy Steering Committee
- Developing a framework for performance management
- Networking with other LHINs
- Working with the regional office for transition of responsibilities
- Working with Cancer Care organizations in Windsor and London
- Participating in the planning process of the Lambton Ministry of Community and Social Services
- Aligning with Cardiac Rehab and Stroke Networks
- Developing an e-Health strategy group
- Served as a planning committee member for the provincial health care expo: Celebrating Innovations in Health care Expo

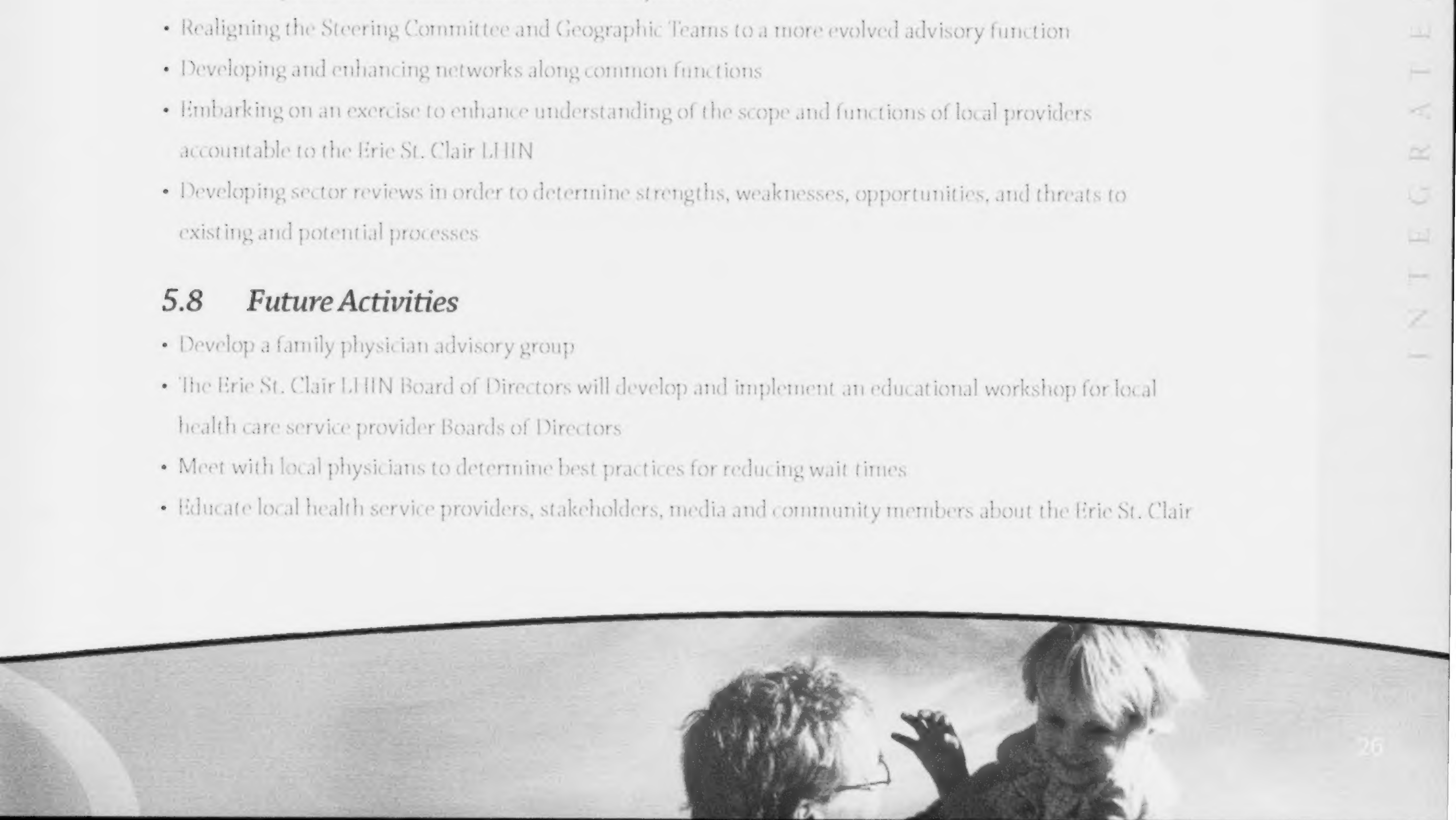
5.7 *Activities in Progress*

As the Integrated Health Service Plan (IHSP) is completed we will focus on:

- Continued community engagement with unique population groups, aboriginal groups and other segments of the population
- The development of the Health Providers Advisory committee
- Realigning the Steering Committee and Geographic Teams to a more evolved advisory function
- Developing and enhancing networks along common functions
- Embarking on an exercise to enhance understanding of the scope and functions of local providers accountable to the Erie St. Clair LHIN
- Developing sector reviews in order to determine strengths, weaknesses, opportunities, and threats to existing and potential processes

5.8 *Future Activities*

- Develop a family physician advisory group
- The Erie St. Clair LHIN Board of Directors will develop and implement an educational workshop for local health care service provider Boards of Directors
- Meet with local physicians to determine best practices for reducing wait times
- Educate local health service providers, stakeholders, media and community members about the Erie St. Clair



Integrated Health Service Plan

- Encourage development and implementation of provincial health care innovations and best practices

Further round table sessions are planned for local aboriginal communities, the hard of hearing community, and other specific communities.

6.0 Strategic Integration Direction Action Plan Summaries

The Erie St. Clair LHIN will act to address the eight strategic integration directions. These strategic integration directions have been grouped into actions for two spheres within the local health care system: Clinical and Clinical Service Related Activities (Part 1) and Structure/Infrastructure/ Process Related Activities (Part 2).The following Action Plan Summaries are based on more detailed action plans available in Appendix G Strategic Integration Directions Action Plans.

6.1 Part I -Clinical/Clinical Service Related Activities

6.1.1 Chronic Disease Management

Erie St. Clair LHIN Actions

- Develop a LHIN wide Chronic Disease Strategy
- Develop a LHIN wide Diabetes Network

Description

Chronic disease management is a pro active, population based approach that addresses chronic illness early in the disease cycle to prevent disease progression and reduce potential health complications. Multiple strategies are used to improve the health of patients diagnosed with specific conditions. This approach reduces the subsequent need for acute interventions and allows people to maintain their independence and health for as long as possible. Chronic disease management must involve all components of the service continuum and requires integrated strategies based on common principles and protocols. These strategies need to differentiate the roles of agencies and practitioners to produce a coordinated and effective process for the management of chronic diseases.

Rationale

In Ontario, a growing number of people age 45 and older are now living with chronic illness. For example:

- Almost 34% have arthritis
- 30% have high blood pressure
- 12% have osteoporosis
- 9% have diabetes
- 8% have asthma

- 6% suffer from depression
- 4% have been diagnosed with cancer
- 2% are currently living with the effects of stroke

Within the Erie St. Clair LHIN:

- 1.11 to 1.42 times as many residents, compared to Ontario, reported arthritis/rheumatism
- 1.08 to 1.29 times as many residents, compared to Ontario, reported diabetes
- 1.23 to 1.29 times as many residents, compared to Ontario, reported asthma
- 1.10 to 1.14 times as many residents, compared to Ontario, reported high blood pressure

A review of specific causes of death in the Erie St. Clair LHIN shows that:

- 32% of Potential Years of Life Lost (PYLLs) to all types of cancer
- 18% of PYLLs to all types of circulatory disease (including heart and stroke)
- 12% of PYLLs to ischaemic heart disease

Strategic Integration Direction Action Projects

Project 1: Develop a LHIN-wide Chronic Disease Strategy

The number of people suffering from chronic disease is increasing. Their treatment and follow up is not uniform. If left untreated or not managed properly, chronic diseases can negatively affect quality of life and lead to other diseases. This demands a strategy that will establish common principles and values, formalized protocols based on best practices, and define roles and relationships to promote a systems approach to the management of chronic disease.

Outcomes

- Improved early detection and follow-up for patients
- Improved mobility and quality of life for people with chronic disease
- Improved health status
- Reduced utilization of some acute health services

Key Activities – Year 1

- Establish a working group and strategic plan for a LHIN-wide approach to chronic disease management

Project 2: Develop a LHIN wide Diabetes Network

Surveys conducted as part of the process for developing the Erie St. Clair IHSP identified a number of groups across the Erie St. Clair LHIN working on ways and means to improve services for residents with diabetes. This

project will facilitate the evolution of a LHIN-wide network for diabetes by building on current initiatives.

Outcomes

- Build on the existing work of diabetes groups
- Assist in the development and implementation of chronic disease management for diabetes for better patient care quality
- Gather expertise from across the Erie St. Clair LHIN

Key Activities – Year 1

- Plan and conduct a LHIN-wide workshop on chronic disease management for diabetes

6.1.2. Reduce Dependence on Hospital Services

Erie St. Clair LHIN Actions

- We will support and facilitate planning for Mental Health System Tier II and Tier III divestment with a focus on appropriate hospital and community-based services
- We will identify strategies for resolving issues related to Alternate Level of Care
- We will develop strategies to support the appropriate use of Emergency Departments

Description

Hospital based services are often the most complex and expensive in the system. Patients often spend too much time in hospital beds because non-hospital services are not available or the patient must wait for services to become available. Hospital emergency services may be the only alternative when primary care services are not available or accessible in a timely way.

Integrated strategies are required to continuously monitor and identify opportunities to reduce the strain on hospital services by providing community-based alternatives when appropriate.

Rationale

- Erie St. Clair LHIN Alternate Levels of Care (ALC) statistics identify 19% of all ALC patients are discharged from hospital without home support
- Some patients may not require hospitalization
- Excessive length of stay and conservable days statistics appear high
- Community engagement participants identified needs for more community care and home based services

Strategic Integration Direction Action Projects

Project 1 – We will support and facilitate planning for Mental Health System Tier II and Tier III divestment, with a focus on appropriate hospital and community based services.

Tertiary psychiatric bed-based services and associated services are to be transferred from St. Joseph's Health

Centre, London to Windsor Regional Hospital as part of the Tier II and III strategies. This transfer provides an opportunity to develop and implement strategies to improve the alignment and configuration of hospital and community-based services across our LHIN. We will support and facilitate the associated planning necessary to produce an efficient and effective mental health system.

Outcomes

- Improved communications between hospital and community sector mental health care providers
- Establishment of consistent operation protocols, policies/procedures across the mental health system
- Establishment of a formal mechanism for conflict resolution between the involved parties
- Establishment of a standard strategic planning format for mental health services system wide
- Improved access to a seamless system of comprehensive mental health services across the region

Key Activities – Year 1

- Establish a working group for mental health divestment
- Develop a divestment plan for non bed-based mental health services

Project 2 - We will identify strategies for resolving issues related to Alternate Level of Care

Alternate Level of Care (ALC) cases are those where a patient is ready for discharge from an acute care hospital bed but the required alternate level of service is not immediately available. For example, a patient unnecessarily remains in an acute bed when their needs could be better met in a less costly alternative setting such as a long-term care facility, but there is a waiting list.

We will establish an ALC working group to conduct a review of patients awaiting transfer from ALC to enhance understanding of patient flow issues, identify patient populations experiencing difficulties accessing community supports, and determine how to improve access to the needed supports.

Outcomes

- Minimize the overall number of ALC days in the Erie St. Clair LHIN
- Improved access to community supports for ALC patients
- Enhanced understanding of patient flow issues across the care continuum
- Development of a standard ALC definition and consistent use of this definition throughout the Erie St. Clair LHIN area
- Increased system flexibility to accommodate periodic increases in ALC demand and utilization related to exceptional circumstances (e.g. flu season)

Key Activities – Year 1

- Establish working group for ALC issues
- Produce a report on issues and solutions for reducing ALCs

Project 3 – We will develop strategies to support the appropriate use of Emergency Departments

Description

Over the past decade there has been a 40% decrease in hospital bed capacity in Canada. An aging population, increased numbers of homeless, de-institutionalized people, and emerging infectious diseases are all straining the capacities of emergency department staff.

The lack of access to primary care services also puts pressure on the emergency department. The inability of patients in the Emergency Departments to access hospital beds is a major issue in Ontario. There is a clear need to reduce emergency department length of stay for patients, but most of the solutions lie beyond the Emergency Departments, which alone cannot address these weighty issues. Unless practices change, the Emergency Departments will not function in their designated role, and will instead inappropriately provide care to patients who should be in inpatient beds or who require access to primary care services.
A working group will be created to identify and implement strategies to use emergency department resources more effectively.

Outcomes

- More appropriate use of the emergency department by LHIN residents
- Improved patient flow within hospitals and between hospital and community sectors
- A safer, less crowded emergency department environment
- Alternatives to emergency department for primary care
- Increased patient satisfaction with Emergency Departments
- Removal of barriers to emergency care

Key Activities – Year 1

- Establish working group for emergency department services
- Work with Southwest Emergency System Network Coordinator
- Create an issues and solutions report for reducing emergency department utilization

6.1.3 Supporting People at Home

Erie St. Clair LHIN Actions

- We will identify integration opportunities and strategies aimed at supporting more people at home

Description

Patient preference for receiving care at home is clearly evident in the Erie St. Clair LHIN. Institutional services are in great demand and are a necessary and costly part of our health care system. Programs and services that assist people to remain at home longer or to leave bed-based services sooner can relieve the pressure on and demand for institutional care. These services can also improve the effectiveness of informal supports, as well as the health and quality of life of individuals. Integration strategies are required to promote efficient, effective and timely home support services.

Rationale

- High volume of acute separations and mental health separations
- High volume of patients awaiting admission to long-term care placement
- High ALC days
- Consistency with provincial end-of-life strategy
- Strong direction from community engagement sessions

Strategic Direction Action Project

Project 1 – We will identify integration opportunities and strategies aimed at supporting more people at home

Currently, there are a number of formal groups (across the Erie St. Clair LHIN area), involving key long-term care and community health care organizations that meet regularly to share information and discuss issues aimed at supporting people at home. We need to establish a Long-Term Care and Community Care working group to oversee and build on the work of these groups in order to advance best practices, better define roles and responsibilities, identify system issues and gaps, and develop options that promote integration across this area.

As the population ages and the demand for service in this area increases, long term care and community care providers will need to be prepared to address these impending changes in a planned and effective manner. A strategic planning process will be initiated and an overall "supporting people at home" framework developed to ensure future success in this area.

Outcomes

- Increased independence of seniors

- Clarification of provider roles and responsibility
- Improved access to service for seniors at home
- More appropriate and enhanced community supports for patients and family caregivers
- A system that is more responsive to future need and growth
- Increased coordination and integration across the Erie St. Clair LHIN area
- Wider development and implementation of best practices for better patient outcomes
- More efficient use of resources (less duplication across the area)

Key Activities – Year 1

- Establish a LHIN-wide Long-Term Care and Common Care working group to create a strategic framework to address issues and find solutions for improving support to people at home

Part II Structure/Infrastructure/ Process Related Activities

6.2.1. Back Office/Administrative Integration

Erie St. Clair LHIN Actions

- We will implement an e-Health Strategy (Fall 2006)
- We will review progress on the Supply Chain Management/ OntarioBuys Initiative and identify opportunities for expansion
- We will establish a working group to explore opportunities to better support small agencies back office functions in the context of broader e-Health Strategy

Description

Increased administrative efficiencies allow for more resources to be placed in the hands of service providers and subsequently into enhanced services. "Back Office" refers to systems that do not deal directly with the customer such as inventory management and accounts payable functions. The LHIN e-Health strategy is one such strategy developed by system partners as a tactic for improving back office functions and administration. The anticipated outcomes resulting from improved health care processes include: increased efficiency, better patient safety and care, and empowered citizens and providers.

Rationale

- Large numbers of small agencies performing their own back office functions are funded by the Ministry of Health and Long-Term Care within the Erie St. Clair LHIN
- Many small agencies lack necessary infrastructure and expertise to provide cost effective administrative services

Strategic Integration Direction Action Projects

Project 1 – We will implement an e-Health Strategy

We have established a local working group to develop an implementation plan for delivering the E Health agenda in Erie St. Clair LHIN.

Outcomes

- Improved health system performance
- Improved client and patient outcomes
- Improved service delivery efficiency

Key Activities Year 1

- Continue to work with the established working group to oversee implementation of (MOHLTC) e-Health Strategy
- Inventory of existing e-Health initiatives in Erie St. Clair LHIN

Project 2 – We will review progress on the Supply Chain Management/ OntarioBuys Initiative and identify opportunities for expansion

A number of health care organizations in the Erie St. Clair LHIN are involved with the OntarioBuys initiatives. OntarioBuys is a government initiative, sponsored by the Ministry of Finance, whose mission is to accelerate the widespread adoption of **Integrated Supply Chain Management** (ISCM) leading practices in Ontario's broader public sector.

We will work with providers in our LHIN currently using OntarioBuys to evaluate the savings and efficiencies achieved by these initiatives and identify opportunities to expand participation by additional agencies.

Outcomes

- Significant cost savings through improved inventory management and automation
- Better pricing
- More efficient supplier networks
- Better needs forecasting
- Implementation of best practices supply chain processes
- Improved communication and response to change
- Better pricing on volume
- Strict contract adherence/compliance with regulatory requirements
- Better identification of supplier performance
- Improved service quality and sustainability

- Real-time supply chain data and trend information
- Paperless materials management environment

Key Activities Year 1

- Develop report on current utilization, costs and benefits of OntarioBuys program in Erie St. Clair LHIN and on the identification of opportunities for expansion

Project 3 – We will establish a working group to explore opportunities to better support small agencies' Back Office functions in the context of broader e-Health Strategy

Many of the participants involved in "Shared Service" and "Back Office" programs are from the larger health care organizations. The working group would identify ways to provide expertise to smaller agencies so they can leverage the benefits of the e-Health Strategy.

Outcomes

- More efficient use of resources and expertise across organizations resulting in increased productivity
- Reduced duplication in back office functions
- Consolidation of resources as transaction activities and expert advice are consolidated into a single structure
- Streamlining and standardization of processes
- Improved communications and more timely access to information
- Development of a greater critical mass needed to support expertise of specialized services (e.g. human resources, legal expertise)
- Establish benchmarks/targets for performance
- Staff retraining and redeployment (focus on core business)

Key Activities Year 1

- Inventory of existing e-Health initiatives in Erie St. Clair LHIN
- Assess current readiness to strategically leverage the back office functions within the context of e-Health Strategy where appropriate

6.2.2 System Navigation

Erie St. Clair LHIN Actions

- We will establish a working group to develop a strategic framework for Health System Navigation

Description

The health care system presents a complex, and at times, confusing array of services making it difficult for patients and/or their families to access the right service at the right time. This frequently results in multiple visits to find the correct service, and a delay in diagnosis and treatment. Strategies and processes need to be developed to help patients and their families navigate through the health care system.

Rationale

- The need for a "system navigator" was frequently identified during the community consultation process
- There are over 150 separate agencies funded by the Ministry of Health and Long-Term Care in the Erie St. Clair LHIN area
- There are 24 Regulated Health Professions, with varied scopes of practice, providing health services that are largely unknown to the general population
- Duplication of services exist causing confusion to the public

Strategic Integration Direction Action Projects

Project 1 – We will establish a working group to develop a strategic framework for health system navigation.

The group would assist in identifying gaps, development of a strategic framework, analysis of current initiatives and opportunities for improvements including greater coordination of existing initiatives and reallocation of resources.

Outcomes

- Agreement on system navigation roles
- Improved access to health care/service information across all population groups
- Fewer people "falling through the cracks"
- More designated system navigation resources
- More culturally appropriate assistance for navigating the health care system
- Increased awareness of health care treatment options to empower patients
- Overall increase in the public's education and understanding of the health care system

Key Activities Year 1

- Development of a strategic framework which will include identification of key issues/gaps/needs regarding system navigation issues
- Produce a report outlining the opportunities to enhance current system navigation initiatives

6.2.3 Health Human Resources

Erie St. Clair LHIN Actions

- We will establish a working group to consider what role we should take regarding Health Human Resources
- We will establish a mechanism to develop and deliver an integrated continuing education program in the area

- We will facilitate the developement and expansion of mentorship programs for health care professionals
- We will establish a working group to examine how the recruitment, training and retention of volunteers can be better integrated and coordinated across the Erie St. Clair LHIN area

Description

Many communities and health service organizations are experiencing difficulty recruiting and retaining qualified health care professionals. Moreover, communities often find themselves competing for scarce resources, such as General Practitioners, Physician Specialists, Registered Nurses, and various Therapists. Research has shown recruitment and retention can be improved through strategies such as provision of continuing education "close to home," and creating a positive/progressive work environment.

Rationale

- The Erie St. Clair LHIN is 20% undersupplied with physician specialists and is 32% undersupplied with General Practitioners compared to the province
- There are current shortages of Registered Nurses, Physiotherapists, Occupational Therapists and Speech Pathologists that will worsen in the next five to 10 years
- Community engagement strongly advocated for recruitment and retention of health care professionals

Strategic Integration Direction Action Projects

Project 1 – We will establish a working group to consider what role we should take regarding Health Human Resources

Although some strategies to address this problem will require provincial leadership, others can be developed and implemented locally. A working group will identify existing successful initiatives and develop a consensus and commitment to move the initiative forward by building on "best practices" and local successes. Examples of some initiatives such as rent subsidies, assistance with spousal employment and re-location incentives can make the region more attractive to health care professionals coming to our LHIN.

Outcome

- Improved supply of local health care professionals
- Stronger position, relative to other geographic areas, to recruit health care professionals
- Improved ability to deliver a comprehensive range of health services at the local level

Key Activities Year 1

- Establishment of a structure, process and strategic framework, leading to identification of the role for the Erie St. Clair LHIN in Health Human Resources
- Develop an inventory of existing initiatives in the area which are targeted at addressing Health Human Resources issues
- Development of a strategy to address recruitment/training of volunteers

Project 2 – We will establish a mechanism to develop/deliver an integrated continuing education program in area

LHIN will seek to build on existing initiatives and develop a coordinated/integrated framework for delivering quality continuing education programs.

Outcomes

- Time savings (away from practice/position), costs savings (conference registrations, etc.)
- Increased participation rates

Key Activities Year 1

- Establishment of a network to develop and deliver continuing education programs to health professionals closer to home

Project 3 – We will facilitate the developement and expansion of mentorship programs for health care professionals

Research has shown mentoring "new" health care professionals (either to organization or profession) has a positive impact on retention rates, and increases the individual's job satisfaction and performance. The Erie St. Clair LHIN will establish a process to identify local formal and informal mentorship programs and help develop a framework leading to a system-wide approach.

Outcomes

- Improved recruitment and retention rates of new health care professionals
- Improved job satisfaction resulting in lower turnover rates
- Lower recruitment and training costs

Key Activities Year 1

- Developing an inventory of existing initiatives in the area, which are targeted at addressing Health Human Resources mentorship opportunities
- Development of a strategy to address recruitment and training of mentors

Project 4 – We will establish a working group to examine how the recruitment training and retention of volunteers can be better integrated and coordinated across the Erie St. Clair LHIN area.

Volunteers play an important role in the health care delivery system, and virtually all health care organizations rely on them for a wide array of services, including governance, fundraising, visiting patients without families and operating gift shops. Many organizations are experiencing difficulties in recruiting and retaining volunteers, due to a range of societal factors. We will work with existing organizations to identify opportunities to improve the recruitment and training of volunteers.

Outcomes

- Improved use of volunteer resources
- Increased numbers of volunteers

Key Activities Year 1

- Conduct a survey of organizations that use volunteers to identify issues regarding recruitment, training and retention of volunteers
- Establish a working group with broad cross sector representation to review survey results and identify opportunities for sharing and coordinating these activities

6.2.4 Health Promotion and Illness Prevention

Erie St. Clair LHIN Actions

- We will partner with existing networks or establish a working group (including Public Health Units) to develop a broader health promotion strategy for the area, which includes addressing the determinants of health

Description

Health promotion can be defined as a process of enabling people to identify, and increase control over, actions to improve their health. The concept of health includes physical, mental, and social well-being dimensions. Illness prevention focuses on strategies that reduce the risk and impact of disease, or the early detection of disease when it is in its most treatable stage. Effective implementation of illness prevention strategies will reduce the burden of illness and disease, and contribute to the overall improved health status of the population.

Rationale

- Compared to Ontario residents, Erie St. Clair LHIN residents report significantly poorer health
- Unhealthy lifestyle rates (e.g. smoking, frequency of heavy drinking, obesity) in Erie St. Clair are higher than provincial rates
- Erie St. Clair LHIN community engagement strongly identified the need for health promotion and illness prevention as a key priority

Strategic Integration Direction Action Projects

Project 1 – We will partner with existing networks or establish a working group (including Public Health Units) to develop a broader health promotion strategy for the area which addresses the determinants of health.

The working group will include membership from a broad range of sectors (e.g. MOHLTC, Ministry of

Education, Ministry of Health Promotion, Ministry of Community and Social Services, Ministry of Children and Youth Services and Ministry of Labour) and will develop a common health promotion framework. The working group will also develop a common data collection system and identify indicators and benchmarks to track and assess population health.

Outcome

- Collaborative health promotion practices among agencies
- Increased public awareness of the benefits of health promotion and support available
- Improved population health
- Improved system-wide population health monitoring, surveillance and reporting capacity
- In the long term, a decrease in health care costs as a result of improved health promotion practices

Key Activities Year 1

- Participate in the development of a common health promotion planning framework which will address the determinants of health and the potential for collaboration between the various sectors.

6.2.5 Timely Access to Appropriate Care and Services

Erie St. Clair LHIN Actions

- We will establish a working group to identify priority issues and develop a strategic plan to improve access, particularly in rural areas
- We will identify gaps and implement strategies to improve primary care access and service
- We will identify priority transportation issues and achievable solutions

Description

Timely access to quality health services is a fundamental principle for the establishment and sustainability of an effective and efficient health care system. Services need to be available when people need them. Currently, access issues have been identified because of a shortage of primary care, excessive wait times for specialty care, a lack of transportation to and from non-urgent care, availability of some testing and screening services, and a need for improved transitions through the health care system. We will assist our partners in identifying strategies where access can be improved.

Rationale

- Wait times data emphasis clearly expresses need
- Emergency room wait times increasing
- Community consultation strongly identified this direction as an opportunity for health system improvement

Strategic Integration Direction Action Projects

Project 1 – We will establish a working group to identify priority issues and develop a strategic plan to improve access, particularly in rural areas

The ability to identify and eliminate access issues and reduce waiting times for services is a key to managing an effective health care system. The MOHLTC has identified wait times for key services as a priority across the province. A working group will be established to identify key issues and appropriate strategies to improve access and reduce wait times for service across the Erie St. Clair LHIN with a particular emphasis on rural issues.

Outcomes

- Identification of problems, gaps, and needs for the rural population
- Measurable reduction in wait times for services
- Reduced patient anxiety
- Earlier diagnosis and treatment for patients
- Improved clinical outcomes for patients

Key Activities – Year 1

- Establish a working group and a strategic plan to improve access to rural health services in the Erie St. Clair LHIN

Project 2 - We will establish a working group to identify gaps and implement strategies to improve primary care access and service

Primary care services are the main access point into the health care system. If access is poor, patients do not receive timely services. Delayed treatment may result in increased illness severity and ultimately increased system costs. The Ministry of Health and Long-Term Care has initiated reform for primary care by creating new models of service and implementing ways and means to attract practitioners. We have a role in improving primary care services

Outcomes

- Increased capacity for primary care services
- Improved consumer satisfaction
- Improved access to other health services for patients
- Timely access to primary care, diagnosis and treatment for our patients
- Improved health promotion and prevention activities
- Health care practitioners are better informed about options for patients

Key Activities – Year 1

- Plan and conduct a LHIN-wide workshop on primary care

Project 3 – We will establich a working group to identify priority transportation issues and implementable solutions

Transportation is a long-standing, complex issue that is problematic throughout the Erie St. Clair LHIN. Various transportation services exist but there are gaps in service and in the public access and awareness of these services. Non-emergency patient transfers between health care agencies in our LHIN and outside our LHIN often experience delays and rescheduling. Patient delays result in system inefficiencies and increased costs. This project will focus on issue identification, issue prioritization, solution identification and implementation activities.

Outcomes

- Improved coordination of health system transportation services
- More efficient use of scarce transportation resources
- Increase understanding by public of available services
- Improved utility of health care resources

Key Activities – Year 1

- Establish a working group consisting of community stakeholders and health service transportation providers to perform a situational analysis and make recommendations
- Develop an Erie St. Clair Family Physician Advisory Group as a forum for engaging in health system planning for both rural and urban communities within the Erie St. Clair LHIN

6.3 Conclusions and Next Steps

This section has briefly identified a series of action plans to support the Erie St. Clair LHIN's eight strategic integration directions. Detailed action plans in support of the above planning outlines are presented in Appendix G. We must now determine the resource requirements, the most appropriate timing, and the evaluation mechanism for the above action plans. Partnership with province-wide initiatives, regional LHIN initiatives, and other agencies and stakeholders will be fully explored in the coming months in order to support our goals.

ENVIRONMENTAL SCAN

APPENDIX A

ENVIRONMENTAL SCAN

APPENDIX A
SECTION 1
POPULATION HEALTH

Population Health refers to the general health of a community. In this case, the five planning areas of Chatham-Kent, Essex County, Lambton County, Erie St. Clair LHIN and Ontario. In most cases, comparisons have been made between the four local areas and Ontario. This is not to suggest that Ontario is the standard, but to indicate how much more or less emphasis the Erie St. Clair LHIN community should place on a particular health factor compared to Ontario's focus. For example, the higher exposure rates to smoking in the Erie St. Clair LHIN than across Ontario overall suggest the local agencies may wish to spend more emphasis than Ontario would on this matter.

As a general comment, the readers should remember that the Mortality-based data are more accurate because determinations are made by professionals and death is unambiguous. The Canadian Community Health Survey results are less accurate, but gauge many more aspects of "health" than mortality and morbidity data. Morbidity data are presented in Appendix B.

Mortality

An upward facing arrow indicates that the rate is significantly higher, while a downward facing arrow indicates that the rate is significantly lower when applying 95% confidence intervals. No arrow indicates that the rate is not significantly different from the Ontario rate. The data presented are a three year average to 2001. This is over five years ago. However, the nature of these mortalities are such that changes over time are usually slow because most of them are the results of lifestyle and environmental choices and associated morbidities are moderated by health care interventions.

Age Standardized Total Mortality (ICD-10 A00-Y89)
rate per 100,000 population, three-year average, 2001

	Both Sexes		Males		Females	
Planning Area	**Rate**	**Sign. Diff.**	**Rate**	**Sign. Diff.**	**Rate**	**Sign. Diff.**
Chatham-Kent	682.9	↑	882.2	↑	540.4	↑
Essex	640.2	↑	784.6	↑	536.0	↑
Lambton	662.1	↑	834.4	↑	530.5	↑
ESC LHIN	653.1	↑	814.3	↑	535.4	↑
Ontario	597.8		741.4		490.2	

Observations

- All planning areas and the Erie St. Clair LHIN as a whole had significantly higher mortality rates compared to Ontario
- Mortality was also significantly higher for circulatory diseases in all planning areas
- The leading causes of death for men were ischaemic heart disease, lung cancer, chronic lower respiratory disease and stroke. For women, the leading causes were ischaemic heart disease, stroke and lung cancer

Potential Years of Life Lost

A Potential Year of Life Lost (PYLL) is calculated by subtracting 75 years from the age at death. This gives more weight to deaths at an earlier age. Again, arrows are used below to simplify interpretation of the table.

Potential years of life lost (PYLL) – All causes of death (ICD-10 A00-Y89), age standardized rate per 100,000 population, three-year average, 2001

	Both Sexes		Males		Females	
Planning Area	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**
Chatham-Kent	5,953.2	↑	7,462.1	↑	4,430.5	↑
Essex	5,031.1	↑	6,048.4	↑	3,983.1	↑
Lambton	5,599.4	↑	6,963.5	↑	4,231.3	↑
ESC LHIN*	5,309.6	↑	6,481.4	↑	4,113.5	↑
Ontario	4,755.4		5,828.6		3,679.2	

Observations

- Erie St. Clair residents have significantly higher PYLL than Ontario residents
- For men, ischaemic heart disease is still the leading cause of PYLL for men, but motor vehicle crashes, lung cancer and intentional self-harm appear in the top four. This reflects the relative youthfulness of persons in serious motor vehicle crashes and causing intentional self-harm
- For women, the leading causes for PYLL are also ischaemic heart disease and lung cancer, but breast cancer and perinatal causes also rank highly

Community Survey of Health Factors

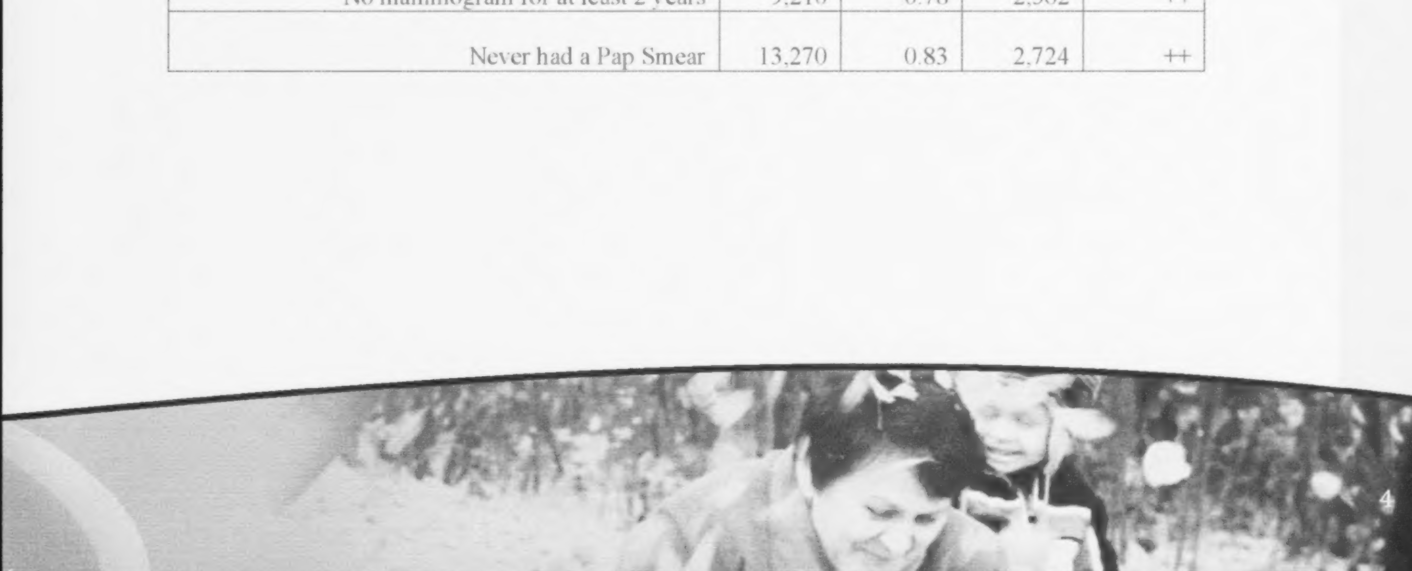
The tables below are taken from the 2005 Canadian Community Health Survey. The data suffer from smaller samples taken in each community, self-reported information (subject to forgetfulness, underreporting of "negative" situations, personal interpretation of "well-being," etc) but they do provide indicators of relative challenges by community. The information, as all the other information in any report, must be validated by

other sources before final decisions are made. The information is invaluable, however, in suggesting areas to pursue further. "Ratio to Ontario" refers to the percentage of persons in each planning area compared to the Ontario percentage. A number higher than "1.00" means the planning area percentage is higher than Ontario's percentage. The "Change to Meet Ontario" shows how many persons would have to change their lifestyle to meet the Ontario percentage. The Ontario percentage is not the "target." This merely provides a numeric indication of how far away from the Ontario percentage each planning area is and therefore the relative importance compared to Ontario, that each planning area may wish to give the item. The "+" in "impact" indicates whether this factor is indicative of better health or ("-") indicative of poorer health.

Healthy Lifestyles

Healthy Lifestyles	Current	Ratio to Ontario	Change to Meet Ontario	Impact
Current daily or occasional smoker	22,372	1.18	(3,375)	--
Overweight or obese Youth	1,490	0.90	183	++
Underweight, BMI under 18.50 Adult	1,483	0.67	719	++
Overweight, BMI 25.00 to 29.99 Adult	26,687	0.98	550	++
Obese, BMI 30.00 or higher Adult	16,573	1.34	(4,293)	--
Participation and activity limitation	28,120	1.04	(1,160)	--
Smoking Initiation: 5 to 14-years-old	21,175	1.19	(3,331)	--
Current daily or occasional smoker	22,372	1.18	(3,375)	--
Exposed to second-hand smoke at home	6,948	1.40	(1,952)	--
Exposed to second-hand smoke in vehicles	7,284	1.37	(1,942)	--
Exposed to second-hand smoke in public places	4,518	0.51	4,360	++
5+ drinks on one occasion, 12+ times a year	16,628	1.11	(1,710)	--
Physically inactive	42,368	1.01	(352)	--
Fruit/vegetable consumption under 5 times/day	53,839	1.10	(4,790)	--
Influenza Immunization 1 or more years ago	19,091	1.06	(987)	++
Influenza Immunization Never	30,061	0.91	3,114	++
No mammogram for at least 2 years	1,659	0.61	1,059	++
Never had a pap Smear	2,777	0.66	1,424	++

	Essex			
Healthy Lifestyles	**Current**	**Ratio to Ontario**	**Change to Meet Ontario**	**Impact**
Current daily or occasional smoker	80,091	1.14	(9,622)	--
Overweight or obese Youth	6,334	1.01	(70)	--
Underweight, BMI under 18.50 Adult	6,496	0.78	1,701	++
Overweight, BMI 25.00 to 29.99 Adult	111,544	1.10	(10,157)	--
Obese, BMI 30.00 or higher Adult	60,402	1.32	(14,690)	--
Participation and activity limitation	104,383	1.04	(4,375)	--
Smoking Initiation: 5 to 14-years-old	70,031	1.07	(4,831)	--
Current daily or occasional smoker	80,091	1.14	(9,622)	--
Exposed to second-hand smoke at home	21,893	1.16	(3,143)	--
Exposed to second-hand smoke in vehicles	23,301	1.17	(3,251)	--
Exposed to second-hand smoke in public places	50,375	1.52	(17,055)	--
5+ drinks on one occasion, 12+ times a year	56,899	1.01	(640)	--
Physically inactive	159,681	1.02	(3,820)	--
Fruit/vegetable consumption under 5 times/day	197,419	1.09	(15,469)	--
Influenza Immunization 1 or more years ago	72,370	1.08	(5,212)	++
Influenza Immunization Never	110,588	0.90	12,476	++
No mammogram for at least 2 years	9,210	0.78	2,562	++
Never had a Pap Smear	13,270	0.83	2,724	++



	Lambton			
Healthy Lifestyles	**Current**	**Ratio to Ontario**	**Change to Meet Ontario**	**Impact**
Current daily or occasional smoker	27,079	1.19	(4,280)	--
Overweight or obese Youth	1,900	0.91	198	++
Underweight, BMI under 18.50 Adult	-	-	2,632	++
Overweight, BMI 25.00 to 29.99 Adult	32,804	1.01	(251)	--
Obese, BMI 30.00 or higher Adult	18,181	1.24	(3,504)	--
Participation and activity limitation	35,945	1.11	(3,589)	--
Smoking Initiation: 5 to 14-years-old	28,845	1.26	(5,994)	--
Current daily or occasional smoker	27,079	1.19	(4,280)	--
Exposed to second-hand smoke at home	8,546	1.41	(2,493)	--
Exposed to second-hand smoke in vehicles	6,879	1.06	(406)	--
Exposed to second-hand smoke in public places	5,337	0.50	5,420	++
5+ drinks on one occasion, 12+ times a year	23,922	1.27	(5,099)	--
Physically inactive	47,542	0.94	2,884	++
Fruit/vegetable consumption under 5 times/day	65,969	1.12	(7,103)	--
Influenza Immunization 1 or more years ago	19,325	0.89	2,403	--
Influenza Immunization Never	41,234	1.04	(1,419)	--
No mammogram for at least 2 years	3,248	0.90	340	++
Never had a pap Smear	3,206	0.63	1,916	++

Observations on Healthy Lifestyles

Compared to Ontario

- There are considerably more smokers in all planning areas
- Current smokers started smoking early in life
- There is more exposure to second-hand smoke at home and in vehicles
- On a positive note, there was much less exposure to second-hand smoke in public places in Chatham-Kent and Lambton County. Essex County was above the Ontario percentage

- Overweight children and adults are generally higher proportions in all planning areas
- Frequent heavy drinking appears more often in Chatham Kent and Lambton County
- In terms of "flu shots," pap smears and mammograms, Erie St. Clair LHIN residents appear to take more responsibility for these items

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Illness and Disability

	Chatham-Kent			
Illness and Disability	**Current**	**Ratio to Ontario**	**Change to Meet Ontario**	**Impact**
With arthritis or rheumatism	17,438	1.11	(1,708)	--
With diabetes	5,716	1.29	(1,284)	--
With asthma	9,467	1.29	(2,142)	--
With high blood pressure	16,410	1.18	(2,409)	--
Injuries within the past 12 months causing limitation of normal activities	11,736	0.95	660	++
1 or more two-week disability periods in last year	13,989	0.89	1,716	++

	Essex			
Illness and Disability	**Current**	**Ratio to Ontario**	**Change to Meet Ontario**	**Impact**
With arthritis or rheumatism	70,437	1.21	(12,086)	--
With diabetes	17,837	1.08	(1,396)	--
With asthma	25,931	0.95	1,243	++
With high blood pressure	57,028	1.10	(5,092)	--
Injuries within the past 12 months causing limitation of normal activities	46,535	1.01	(553)	--
1 or more two-week disability periods in last year	62,201	1.07	(3,943)	--

	Lambton			
Illness and Disability	**Current**	**Ratio to Ontario**	**Change to Meet Ontario**	**Impact**
With arthritis or rheumatism	26,790	1.42	(7,912)	--
With diabetes	6,185	1.17	(866)	--
With asthma	10,809	1.23	(2,017)	--
With high blood pressure	19,144	1.14	(2,341)	--
Injuries within the past 12 months causing limitation of normal activities	14,784	0.99	93	++
1 or more two-week disability periods in last year	21,031	1.12	(2,183)	--

Observations on Illness and Disability

Compared to Ontario

- There is a higher prevalence of diagnosed arthritis/rheumatism, diabetes, asthma and high blood pressure in all three planning areas except that there is a lower prevalence of asthma in Essex County. These are all chronic diseases
- There were more people with one or more two week disability periods in Essex County and Lambton County

Perceptions about Health

If peoples' beliefs about their health status differ from actual "facts," it suggests that a health persuasion program may be required before health promotion and education can be implemented.

	Chatham-Kent			
Perceptions about health	**Current**	**Ratio to Ontario**	**Change to Meet Ontario**	**Impact**
Fair or poor health	8,307	0.82	1,820	++
Fair or poor mental health	4,035	0.90	501	++
Very weak sense of belonging to community	6,309	0.74	2,258	++
Quite a lot of life stress	17,581	0.92	1,533	++

	Essex			
Perceptions about health	**Current**	**Ratio to Ontario**	**Change to Meet Ontario**	**Impact**
Fair or poor health	45,361	1.21	(7,795)	--
Fair or poor mental health	14,877	0.90	1,949	++
Very weak sense of belonging to community	30,809	0.97	971	++
Quite a lot of life stress	70,181	0.99	647	++

	Lambton			
Perceptions about health	**Current**	**Ratio to Ontario**	**Change to Meet Ontario**	**Impact**
Fair or poor health	12,933	1.06	(779)	--
Fair or poor mental health	4,607	0.86	837	++
Very weak sense of belonging to community	4,925	0.48	5,357	++
Quite a lot of life stress	22,025	0.97	762	++

Observations about Perceptions of Health

Compared to Ontario

- All perceptions of health, belonging, and stress are more positive in Chatham-Kent in spite of actual higher mortality and morbidity
- Essex County and Lambton County residents report more fair or poor general health, but more positive for all other factors

Use of Providers

The rising use of funding alternatives to OHIP billings, the availability of alternative health providers, the range of non-OHIP funded mental health professionals, and the private nature of most dental practices make it difficult to gather provider use information any way other than through the CCHS. The tables below present information based on the previous year's contacts (from 2005).

	Chatham-Kent			
Use of Providers	**Current**	**Ratio to Ontario**	**Change to Meet Ontario**	**Impact**
Does not have a regular medical doctor**	5,855	0.73	2,261	++
Contact with alternative health provider/s	9,542	0.87	1,500	++
Contact with a health professional about mental health	6,828	1.06	(358)	--
No contact with dental professional	34,904	1.26	(7,205)	--

	Essex			
Use of Providers	**Current**	**Ratio to Ontario**	**Change to Meet Ontario**	**Impact**
Does not have a regular medical doctor**	41,676	1.39	(11,570)	--
Contact with alternative health provider/s	37,888	0.93	3,072	++
Contact with a health professional about mental health	24,472	1.03	(471)	--
No contact with dental professional	90,364	0.88	12,388	++

	Lambton			
Use of Providers	**Current**	**Ratio to Ontario**	**Change to Meet Ontario**	**Impact**
Does not have a regular medical doctor**	6,856	0.70	2,884	++
Contact with alternative health provider/s	13,650	1.03	(398)	--
Contact with a health professional about mental health	8,935	1.16	(1,170)	--
No contact with dental professional	29,852	0.90	3,391	++

Observations about use of Health Providers

Compared to Ontario

- Fewer Chatham-Kent and Lambton County residents report not having a regular physician, but Essex County residents report that quite a few more do not have a regular doctor. This will drive higher rates of ER and after-hours use in Essex County

- Slightly more Lambton County residents report use of alternative health providers
- More Lambton County residents reported contact with a mental health professional
- More Chatham-Kent residents reported no contact with a dental professional

Key Findings about Population Health

- Mortality and Potential Years of Life Lost are significantly higher in all planning areas, compared to Ontario
- Lifestyles are worse across the Erie St. Clair LHIN than across Ontario
- Residents beliefs about health reflect mortality and life expectancy in Essex County and Lambton County
- However, Chatham-Kent residents believe they are healthier than they actually are
- Erie St. Clair residents have more chronic diseases
- Health education and promotion is crucial to address both wrong perceptions in Chatham-Kent as well as actual high mortality and morbidity rates across the Erie St. Clair LHIN
- Focus on prevention and care management is essential

STRUCTURE AND UTILIZATION OF THE HEALTH CARE SYSTEM

SECTION 2

This section will touch on key points in the structure and use of the health care system, focussing on services and programs funded by MOHLTC. Further details can be found in Appendix B: Health System Monitoring Report. In some cases, substantial revenue comes from non-MOHLTC sources but the facilities are still included within the MOHLTC "family." The review will be indicative, not conclusive in nature. Although the information may appear to use common words and definitions, the reader must be careful when making some direct comparisons. The key issue is how much interpretation can be made from any one set of information.

The data sources are, where possible, received directly from the providers and from their datasets (for example, from hospitals directly or from CIHI, directly from the CCACs for some utilization data, from DATIS for the substance abuse and problem gambling services). To add to this information, use of various MOHLTC sources that are in general use by providers was also included. The primary MOHLTC source was from the MOHLTC FIM website. This is an evolving and expanding tool of essential use to all funders, planners and providers.

It is not without faults, but allows discussions to begin. Ministry of Finance Population Projections are used up to 2016. 2016 is used as the upper end for projections because it is 10 years from 2006 – the date of this IHSP. It is well known that confidence in population projections weakens as the horizon increases, but it is essential to have insight into where current situations may go if no change is made. This allows the reader to focus on their view of high and low change situations as they prioritize their future activities.

Hospital Services

Emergency Rooms

Emergency Rooms are the window into hospitals. They are the site of care for a large proportion of patients seen in hospital.

The table below shows the volume of ER visits for the last three years in Erie St. Clair.

Observations

- Volumes increased in 2004/05 after the SARS-impacted volumes of 2003/04, but declined in 2005/06
- The decline is primarily in Essex County and Chatham-Kent, while volumes remained steady in Lambton County

- Decrease in volumes may indicate higher use of walk in clinics in Essex County and an expansion of family physicians' office hours in Chatham-Kent. Ongoing monitoring of these trends will be done to determine if there is a continuing impact on ER volumes as a result of these initiatives

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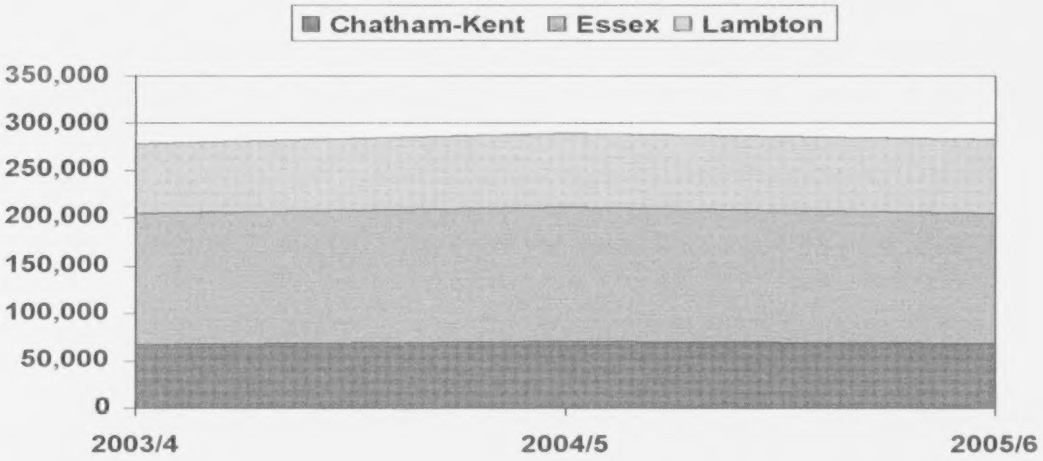
Emergency Room Visits in ESC



The table below shows the origin and site of service for Erie St. Clair ER services for 2005/06.

Observations

- Most residents receive services in their community
- Over 4,000 Chatham-Kent ER visits were by Lambton County residents
- Over 3,000 Essex County ER visits were by Chatham-Kent residents
- These two observations are in part due to the proximity of Wallaceburg to Lambton County and Leamington to Chatham-Kent

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ER Visits by Residence, 2005/06

	Hospital Location		
Residents of	**Chatham-Kent**	**Essex**	**Lambton**
Chatham-Kent	61,296	3,427	703
Essex	776	130,930	180
Lambton	4,513	108	75,342
Other	1,345	2,866	2,221

The table below shows the triage level of ER patients in 2005/06.

Observations

- Very few patients required resuscitation
- About 10% required emergent care
- Between 41% (Essex) and 66% (Chatham Kent) required less urgent or non-urgent care. These are people who may have benefited from non-ER primary care

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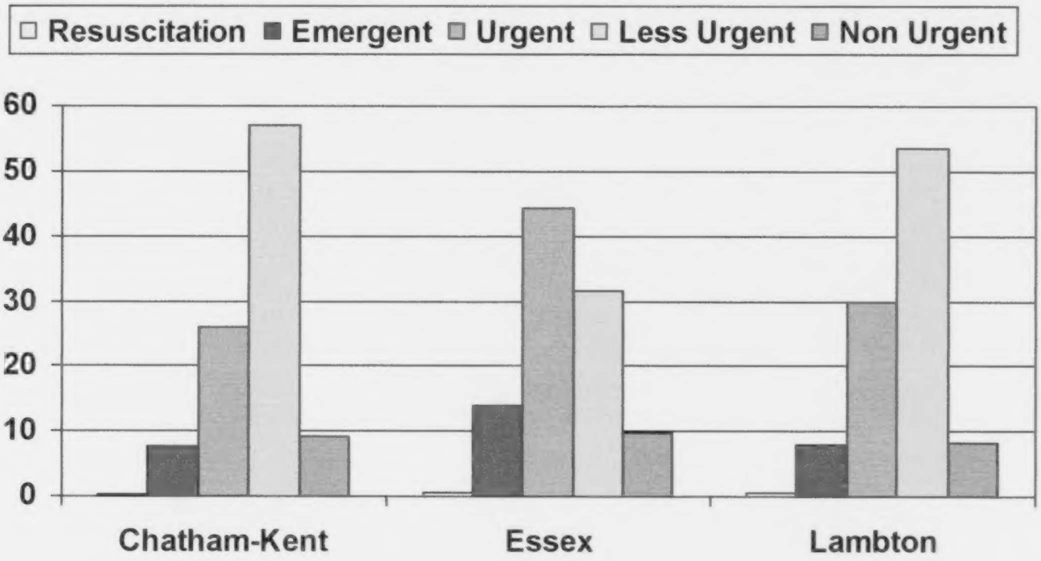
Percentage of Cases by Triage Level in ER, 2005/06



The table below shows the discharge disposition of ER patients in 2005/06.

Discharge Disposition	Chatham-Kent		Essex		Lambton		ESC LHIN	
	2004/05	2005/06	2004/05	2005/06	2004/05	2005/06	2004/05	2005/06
	%	%	%	%	%	%	%	%
Discharged to Place of residence (Includes home and residential institution)	87.2	87.2	78.2	76.9	88.9	89.6	83.2	82.9
Left Without Being Seen	3.9	3.6	4.4	5.5	1.8	1.4	3.6	3.9
Left Prior to Completion of Treatment	0.4	0.9	2.0	2.2	0.4	0.8	1.2	1.5
Admitted as an In-Patient	7.7	7.5	14.0	14.0	7.9	7.3	10.8	10.6
Transferred to Another Facility	0.5	0.5	1.0	1.1	0.4	0.4	0.7	0.7
Death	0.1	0.1	0.2	0.2	0.1	0.1	0.1	0.2
Transferred to Another Ambulatory Department	0.2	0.2	0.2	0.2	0.4	0.4	0.3	0.3

Observations

- 85% of patients go home, 11% are admitted and 5% leave before treatment is completed
- The average time between triage and discharge is three hours
- The cost of ER services in Erie St. Clair LHIN is $49M (2005/06)
- Five organizations provide ER services on seven sites in Erie St. Clair

Key implications regarding emergency room services:

- A better primary care system is required to reduce the non-urgent and deferral patients using ER
- Timeliness of care is a challenge
- ER services are distributed throughout the LHIN

Inpatient Hospital Services

This includes regional mental health services and complex continuing care (i.e. chronic care), which are described separately in this section.

The table below shows the weighted cases (the best indicator of workload) for Erie St. Clair LHIN facilities.

- The total volume is very stable over the three-year period across all planning areas
- About two-thirds of the Erie St. Clair volume is provided by Essex County facilities with the remainder almost equally split between Chatham-Kent and Lambton County
- The top three Patient Cluster Categories are cardiology, obstetrics and gastro-hepatobiliary diseases. This roughly mirrors Ontario figures
- The average cost per weighted case was $4,575 (compared to $5,006 in Ontario overall)
- There was a 14% higher separation rate and 9% higher day rate/1,000 in Erie St. Clair than in Ontario overall
- Alternate Level of Care (ALC) days are shown to be increasing in the Erie St. Clair LHIN for 2005/06. On average, 78 beds in the Erie St. Clair LHIN are occupied by patients who could be more appropriately treated in a setting other than acute care. Efforts are underway in the Erie St. Clair LHIN to ensure consistency of reporting across all hospitals. Additionally, working groups will be established to investigate potential solutions for those patients identified as requiring an alternate level of care
- The cost of the subset of acute care services was $283M in 2005/06
- Five organizations provide these services on eight sites in Erie St. Clair

Acute Weighted Cases by Planning Area*

Facility PA	2003/04	2004/05	2005/06
Chatham-Kent	10,553	9,810	10,215
Essex	39,623	39,809	39,805
Lambton	11,899	11,930	11,917
Erie St. Clair	62,075	61,549	61,937

*excluding IP Mental Health services, shown later

Acute Care Mental Health Inpatient Services

In 2005/06:

- 4,000 patients received 41,000 days of care
- The separation rate/1,000 population was significantly higher for Erie St. Clair residents than for Ontario overall
- The cost for acute/short term inpatient mental health services in Erie St. Clair was $21M
- The average cost per day (a simple measure of cost) was $500
- Four organizations provide these services on four sites in Erie St. Clair

Regional Mental Health Inpatient Services

In 2005/06:

- Erie St. Clair residents received almost all of their tertiary/regional services in London or St. Thomas
- There were 134 discharged patients who received 24,000 days of care
- Half of the discharged patients were discharged home and 16% to an outpatient facility
- Half of the discharged patients were readmissions
- Half of the patients were referred from an acute care inpatient mental health facility (most likely an Erie St. Clair facility)
- Another quarter of the discharged patients had been referred from ER or the mental health out-patient program
- Cost data are not available

Acute In-Patient Rehabilitation

In 2005/06:

- 2,276 patients received 40,000 days of care
- One third of patients are discharged home and another one-third of discharges are not coded for discharge location
- The cost for acute inpatient rehabilitation in Erie St. Clair was $22M
- The average cost per day (a simple measure of cost) was $530
- Five organizations provide these services on five sites in Erie St. Clair

Complex Continuing Care

In 2005/06:

- 103,000 days of care were provided. Due to the length of stay for this service and the occupancy rate, the numbers of patients under care at any one time was about 256
- The average cost per weighted day of care was $477 in Erie St. Clair
- Four organizations provided care on six sites in Erie St. Clair
- The cost for complex continuing care was $47M

Hospital-based alternatives to In-Patient Care

The following services are generally seen as alternatives to either an admission to acute in-patient care or supporting a reduction in length of stay.

Day Surgery

In 2005/06:

- 66,000 visits were made in Erie St. Clair facilities
- There was a 6% increase in workload since 2003/4
- Five organizations provided care on seven service sites in Erie St. Clair
- The cost for day surgery services was $60M in Erie St. Clair

Day/Night Care

In 2005/06:

- There were 160,000 visits
- There was a 14% increase in visits since 2004/5
- Five organizations provided care on eight service sites in Erie St. Clair
- The cost for day/night care was $23M in Erie St. Clair

Clinics

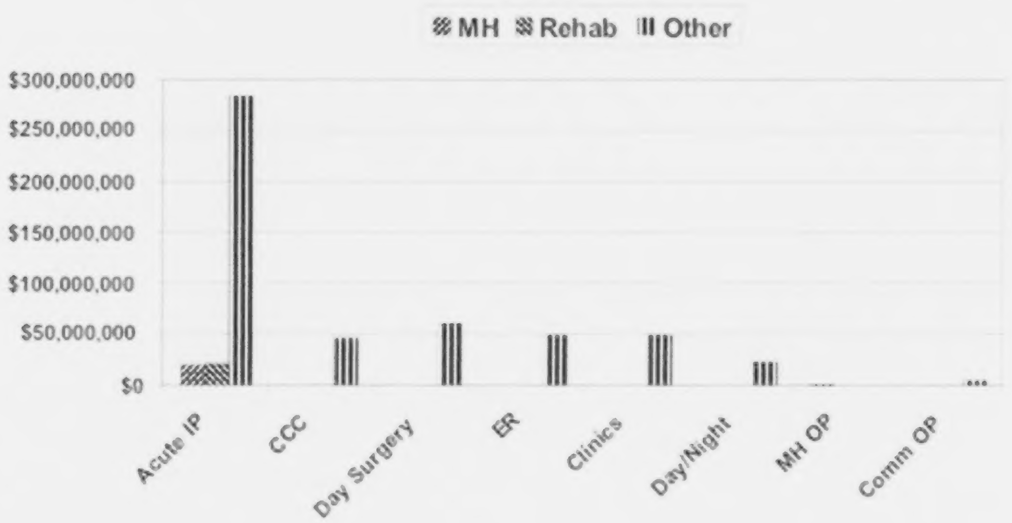
In 2005/06:

- There were 291,000 visits
- There was a 4% decrease in visits since 2004/5. There were decreases at all sites
- Five organizations provided care on seven service sites in Erie St. Clair
- The cost for clinics was $49M in Erie St. Clair

Key Findings for Hospital Services

The chart below shows the funding allocations for major hospital programs in 2005/06.

Cost Allocation, 2005/06*



- $562M was spent by five Erie St. Clair hospital organizations
- In-patient costs (Mental Health, Rehabilitation, Complex Continuing Care and "Other") were two thirds of total allocated hospital expenses in 2005/06
- Additional services were provided to Erie St. Clair residents outside of the LHIN facilities
- The large volume of readmissions and discharges to home for many regional mental health patients requires attention to optimize care

Non-Institutional Services

To avoid the confusion over the definition of "community" and which agencies are "community" and which are not, non-hospital-based services are referred to as non-institutional services. In this discussion, this includes:

- Community Care Access Centres (CCACs)
- Community Support Services (CSS)
- Children's Treatment Centres (CTCs)
- Substance Abuse and Problem Gambling Services
- Physicians
- Community Mental Health Services (no data are provided in this report on this item)

Community Care Access Centres

The information presented in this report is gathered from the two organizations that were in place in 2005/06. Before year-end 2006/07, there will be one CCAC serving Erie St. Clair LHIN.

In 2005/06:

- There were 21,000 admissions and 30,000 persons under care. This includes 3,700 persons receiving long term care placement services. Persons could be receiving both in-home care and LTC placement services at the same time and so would be counted twice
- Both CCACs provided school-based, in-home programs, end-of-life and long term care placement programs
- Waiting times were less for almost all service categories compared to Ontario averages, with the exception of school health. The difference did not appear significant to the child or the system.• The total expenses were $82M over two agencies

Community Support Services

"Community Support Services" (CSS) encompasses a wide range of specialized services designed to support persons outside of institutions. The funded organizations range from hospitals to long term care facilities to very small, focused agencies in small communities. Standardized utilization information is difficult to gather and efficiency measures between agencies are also difficult to interpret. The table below shows the types of services funded in 2005/06 by MOHLTC in Erie St. Clair.

Community Support Services Programs, 2005/6*

	Planning Area				
Service	Chatham-Kent	Essex	Lambton	ESC LHIN	Ontario
Adult Day Service (Alzheimers/Other Aging Dementia)	1	1	2	4	58
Adult Day Service (Frail Elderly)	0	0	2	2	25
Adult Day Service-Integrated-Frail/Alzheimers/Other Dementia	1	2	1	4	103
Adult Day Service	1	1	0	2	11
Alzheimers/Dementia Overnight Service	0	0	1	1	9
Meals on Wheels	5	6	2	13	161
Diners Club/Wheels to Meals/Congregate Dining	0	1	1	2	164
Transportation	2	7	2	11	183
Home Maintenance and Repair (Brokerage)	0	1	2	3	88
Friendly Visiting	1	3	1	5	152
Security Checks/Reassurance Service	1	5	1	7	120
Caregiver Support - Support and Counselling	2	2	0	4	61
Caregiver Support - Training, Information and Education	2	1	1	4	63
Caregiver Support (Paid Staff)	1	1	1	3	47
Caregiver Support - Volunteer Hospice Visiting Service	1	1	1	3	77
Caregiver Support (Volunteer)	0	0	2	2	18
Extended Respite Service	0	0	1	1	5
Home Help/Homemaking (Paid)	0	0	1	1	64
Public Education Coordinator	1	1	1	3	40
Psychogeriatric Consulting Services (Alzheimer Strategy)	0	1	0	1	23
Foot Care	1	3	0	4	45
Client Intervention and Assistance Service (Seniors)	0	0	1	1	59
Geriatric Assessment Program - Windsor	0	1	0	1	2
Homemaking/Personal Supp/Attendant - Elderly in SHU	1	1	0	2	104
Supportive Living Service - Physically Disabled Adults	1	1	1	3	65
Homemaking/Personal Supp/Attendant/Respite-Phys Dis Outreach	1	1	1	3	46
Supportive Living Service - ABI in SHU	0	1	0	1	19
Case Management	1	0	1	2	16
Special Services For the Blind and Visually Impaired	0	1	0	1	21
Special Services For Persons with Acquired Hearing Loss	0	1	0	1	14
Non LTC Pay Equity	5	7	2	14	78
Total Funded Programs	29	51	29	109	2,373

*MOHLTC FIM website

Observations

In 2005/06:

- There were 30 different service types delivered in the Erie St. Clair LHIN through 95 funding agreements between agencies and the MOHLTC
- There were another 26 service types delivered somewhere in Ontario, but not in the Erie St. Clair LHIN. Some are related to aboriginal populations and palliative care. It is not known if local CSS agencies have applied for these types of programs and whether there is a perceived local need or not
- Not all services within the Erie St. Clair LHIN are offered in all planning areas
- There are 28,000 clients on the combined service lists. It is assumed that some persons are on more than one service list and could also be receiving hospital, CCAC and other services. There is no mechanism to track multiple service persons

- There are a total of 52 organizations spending a total of $17.4M. This includes revenues from sources other than MOHLTC

Children's Treatment Centres

There are three Children's Treatment Centres (Prism Centre for Audiology and Children's Rehabilitation, John McGivney Children's Centre, Pathways Health Centre for Children) in the Erie St. Clair LHIN. They serve children aged 0 to 19 years who have physical, communication or developmental needs. Some children receive more than one service. The children may also receive other services from CCAC, hospitals, etc. or the CTC may be contracted to provide services on behalf of the CCAC.

Children's Treatment Centres, 2005/06*

Individuals Served by Service

Planning Area	Physiotherapy	Occupational Therapy	Speech Language /Pathology	Audiology	Social Work
Chatham-Kent	302	287	721	1,582	203
Essex	470	490	294	-	385
Lambton	307	688	503	663	168
ESC LHIN	1,079	1,465	1,518	2,245	756
Ontario	11,400	12,667	10,987	3,132	7,202

*MOHLTCFIM website

Observations

In 2005/06:

- The CTCs provided physiotherapy, occupational therapy, speech/language pathology, social work and audiology services. Not all agencies provide the same services, nor do they all provide all services
- They were jointly funded by MOHLTC and other ministries as well CCACs and other sources
- Although cost per visit and per workload unit are provided, the numbers did not appear to be truly comparable
- There were between 2,200 and 4,000 children seen based on the data available. As with CSS agencies noted above, it is assumed that some persons are on more than one service list and could also be receiving hospital, CCAC and other services. There is no mechanism to track multiple service persons
- There were three sites operated by three organizations
- The total expenses were $14.7M

Substance Abuse/Problem Gambling

The MOHLTC funds agencies to provide a range of services for those with substance abuse (alcohol and drugs) and problem gambling. The nature of these conditions means that many organizations (work, school, non governmental organizations (NGOs), churches, hospitals, etc.) operate programs and services to help address these needs. However, this section provides data only related to those services provided through funding by the MOHLTC specifically for substance abuse and problem gambling.

Substance Abuse and Problem Gambling Programs in Erie St. Clair LHIN, 2005/06*

	Chatham-Kent		Essex		Lambton		Erie St. Clair	
Program	**SA**	**PG**	**SA**	**PG**	**SA**	**PG**	**SA**	**PG**
Initial Assessment Treatment Planning	1	1	3	1	1	1	5	3
Case Management	1	1	2	1	1	1	4	3
Community Treatment	2	1	3	1	1	1	6	3
Community Day/Evening Treatment Services			1	1	1		2	1
Community/Medical Psychiatric Treatment Services					1		1	
Residential Withdrawal Management Services Level 1			1				1	
Residential Treatment Services			3	1			3	1
Community Withdrawal Management Services	offered in Ontario, but not ESC LHIN							
Residential Support Treatment Services	offered in Ontario, but not ESC LHIN							
Residential Medical/Psychiatric Treatment Services	offered in Ontario, but not ESC LHIN							

*DATIS, CATALYST Jul 2006 for ESC LHIN facilities

Observations

In 2005/06:

- Not all service types available in Ontario are available in Erie St. Clair
- Some services were available in all planning areas
- There were about 3,300 new admissions for substance abuse or problem gambling in Erie St. Clair LHIN facilities. Almost all were residents of the Erie St. Clair LHIN
- There were a further 1,400 new admissions by Erie St. Clair residents but the location was not noted. Very few Erie St. Clair residents were reported in London
- Overall, 59% of referrals were from self/family/friends. Under 6% were from hospitals and 0.3% were from Community Health Centres
- Two-thirds of the new admissions for substance abuse were male
- Just under 50% of the new admissions for problem gambling were male
- Seven organizations provide services on seven sites
- The total expenses were $6.3M

Physicians

Specialist Physicians

Based on 2004 data and applying simple per capita ratios, the following table shows the status of specialist physicians in the Erie St. Clair LHIN, compared to Ontario. It must be clearly noted that the "Shortage" figures is the simple difference between the Ontario ratio of specialist physicians compared to the Erie St. Clair ratio. It gives an indication only of the shortage of physicians. However, using these numbers to develop physician recruitment programs would not be appropriate. They may not reflect true numbers in some specialty areas because the Erie St. Clair LHIN will continue to use the services of specialist physicians in the Southwest LHIN, These physicians should be allocated there, rather than to Erie St. Clair. The numbers are useful, however, because they give relative impacts of physician supply and highlight areas where current and future adjustments in service are needed.

ESC LHIN Specialist Physician Status, 2004*

Shortages based on Ontario per capita supply

Specialty	Shortage (rounded)	% Short
Geriatric Medicine	-5	-100%
Hematology	-6	-86%
Infectious diseases	-3	-75%
Rheumatology	-6	-75%
Psychiatry	-59	-63%
Nephrology	-5	-63%
Physical Medicine & Rehab	-5	-63%
Cardiology	-15	-60%
Paediatrics	-26	-53%
Gastroenterology	-6	-50%
Thoracic Surgery	-1	-50%
Anatomical Pathology	-6	-46%
Neurology	-6	-46%
Plastic Surgery	-4	-44%
Laboratory Medicine	-10	-43%
Orthopaedic Surgery	-9	-41%
Community/Public Health	-2	-40%
Endocrinology	-3	-38%
Anaesthesia	-18	-37%
Respirology	-4	-36%
Dermatology	-3	-33%
Ophthalmology	-7	-33%
Cardiothoracic	-1	-25%
Radiation Oncology	-2	-25%
General Internal Medicine	-7	-23%
Diagnostic Radiology	-9	-22%
Otolaryngology	-2	-17%
Obs/Gynecology	-4	-12%
Total Specialists	-237	-40%

General/Family Practitioners

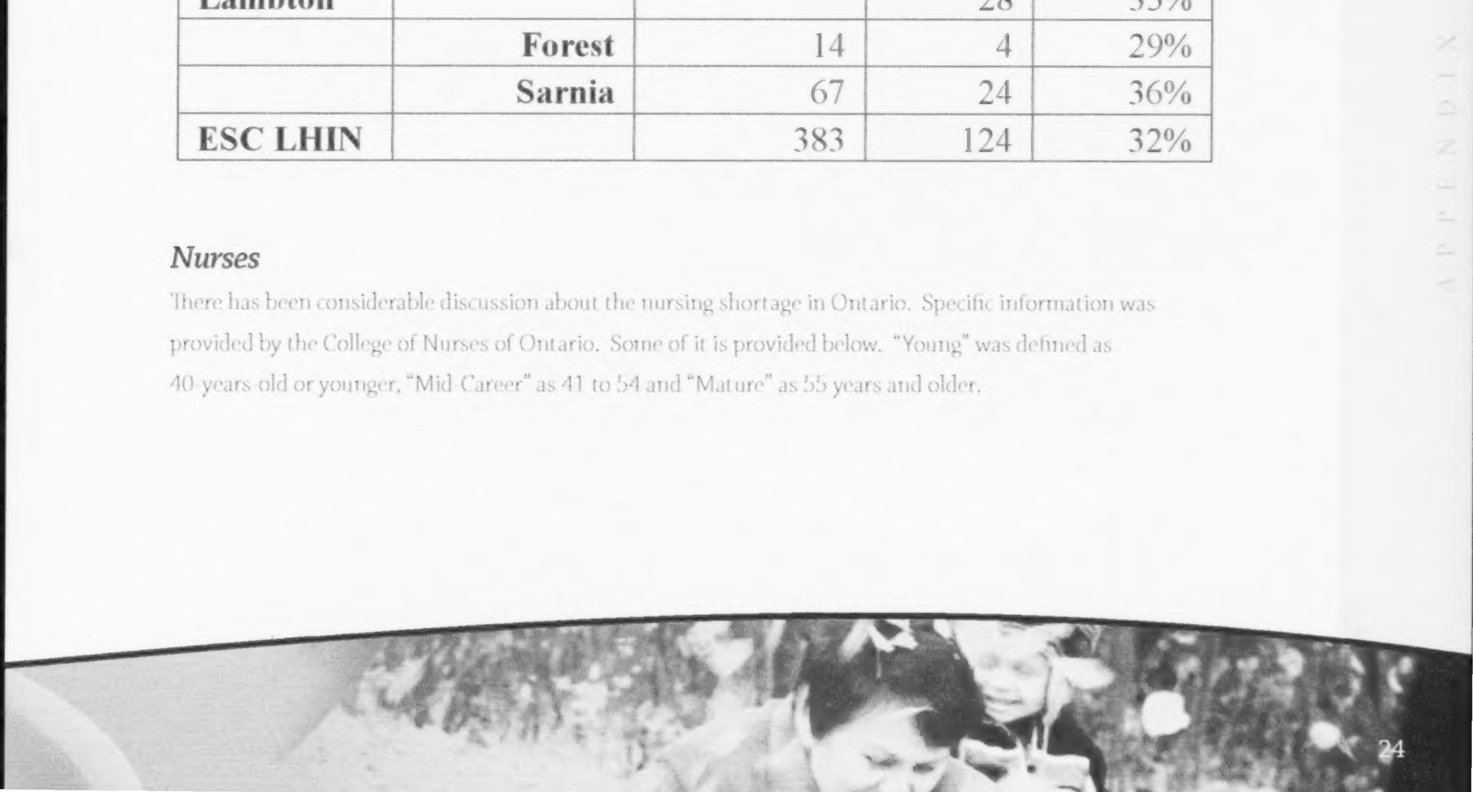
The province has a special "Underserviced Areas Program" for General/Family Practitioners. The tables below are taken from that source. The information is valid for April/May/June 2006.

GP Designated Underserviced Areas, April/May/June 2006

		Complement	Vacancy	% shortage
Chatham-Kent				
	County	69	20	29%
Essex County			76	33%
	Amherstburg	13	7	54%
	Essex	11	8	73%
	Harrow	6	5	83%
	Kingsville	26	9	35%
	Lakeshore	13	10	77%
	Windsor	164	37	23%
Lambton			28	35%
	Forest	14	4	29%
	Sarnia	67	24	36%
ESC LHIN		383	124	32%

Nurses

There has been considerable discussion about the nursing shortage in Ontario. Specific information was provided by the College of Nurses of Ontario. Some of it is provided below. "Young" was defined as 40 years old or younger, "Mid-Career" as 41 to 54 and "Mature" as 55 years and older.



Nurses Employed in Erie St. Clair by Type and Practice Sector, 2005

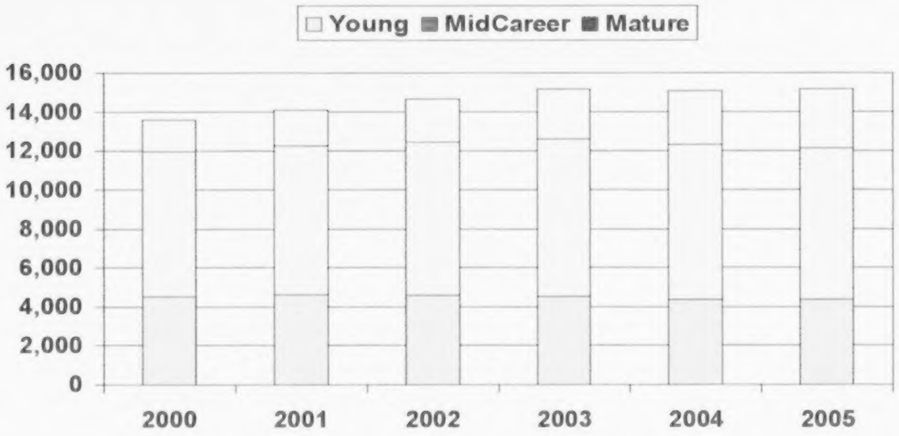
	RN General Class		RPN		RN-Extended Care	
Sector	**Number**	**%**	**Number**	**%**	**Number**	**%**
Hospital	2,446	58%	565	41%	**	**
Long Term Care	471	11%	512	37%	*	*
Community	892	21%	**	**	*	*
Other	335	8%	*	*	*	*
Not Specified	108	3%	73	5%	1	2.2
Total	**4,252**	**100**	**1,385**	**100**	**46**	**100**

Source: CNO, Sept. 2006

*numbers suppressed due to small cell count

**adjacent cell suppressed to ensure confidentiality

Employed Nurses in CNO Southwest Ontario



Other Selected Health Professions

The table below may contain some persons who are inactive, but still registered. The numbers should, therefore, be treated as overcounts.

Selected Health Professions' Supply, 2005/06

	Members		Members/100K residents		
Health Profession	**ESC LHIN**	**Ontario**	**ESC LHIN**	**Ontario**	**Ratio ESC:Ontario**
Pharmacists	437	10,351	67.6	82.5	0.82
Occupational Therapists	138	4,010	21.4	32	0.67
Physiotherapists	239	6,080	37	48.5	0.76
Dietitians	85	2,609	13.2	20.8	0.63
Midwifery	8	334	1.2	2.7	0.44
Registered Nurses	4,252	89,050	657.8	710.1	0.93
Registered Nurses - Extended	46	583	7.1	4.7	1.51
Registered Practical Nurses	1,385	24,480	214.3	195.2	1.10

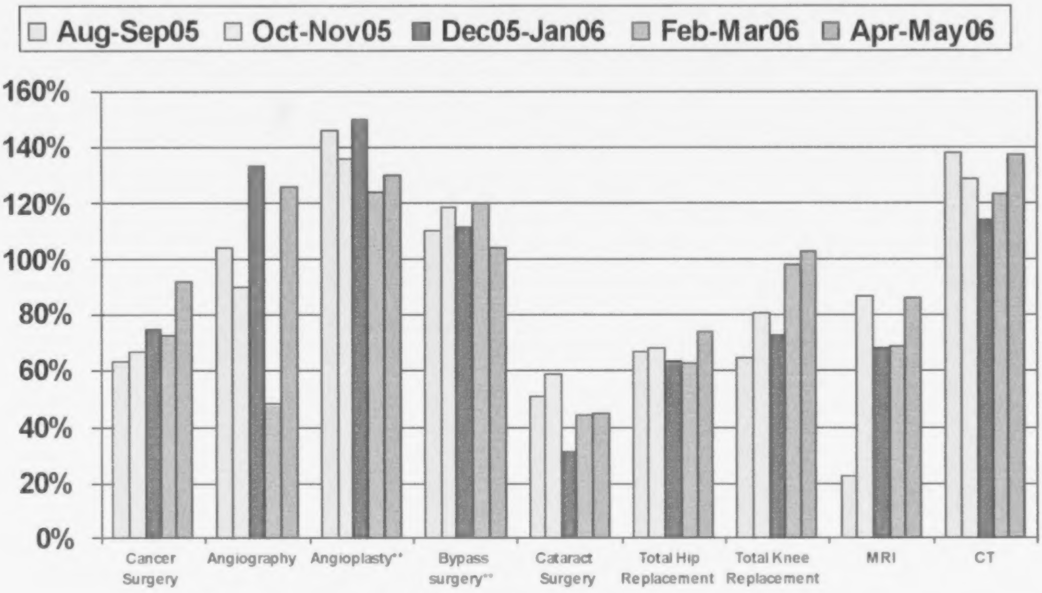
Observations

- There are shortages in specialist physicians in many areas
- The Erie St. Clair LHIN is short 124 General/Family Practitioners in 2005/06
- There are only 46 Extended Care RNs employed in the Erie St. Clair LHIN
- Almost 60% of RNs and 41% of RPNs work in hospitals
- The simple per capita ratios for selected health professions show that the Erie St. Clair LHIN is undersupplied in all listed categories except Extended Practice RNs and RPNs. Combined, these two apparent "oversupplied" categories do not counteract the undersupply of RNs
- In Southwest CNO Region, young career nurse supply has been declining since 2001 and overall supply has been declining since 2003

Waiting Times

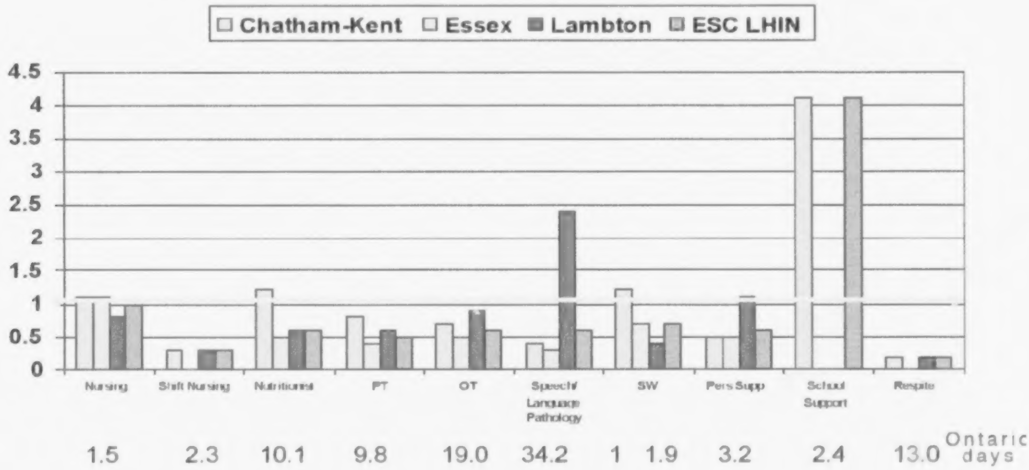
Waiting times create challenges throughout every community. They affect work, school, other providers and families in addition to their impact on the individual affected. Unfortunately, waiting times are very challenging to collect and, often, to interpret. Data are available for selected hospital procedures, CCAC services and Children's Treatment Centres. All the numbers should be viewed with some caution.

Hospital Waiting Times: Selected Procedures, ESC LHIN
90%ile times

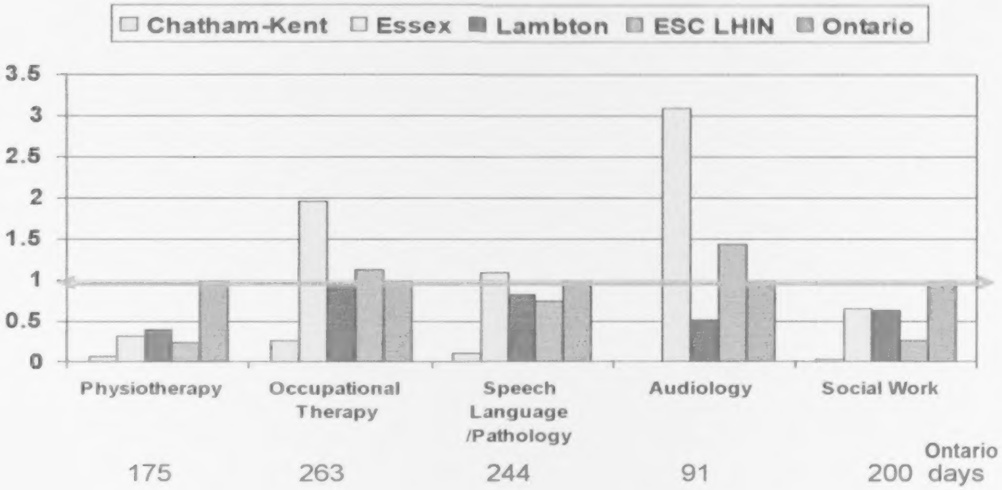


** services not provided Erie St. Clair LHIN, Southwest figures shown

CCAC Average Wait Times ratio to Ontario Averages



CTC Average Wait Times ratio to Ontario Averages



Observations

- Waiting times for selected hospital procedures show that cancer surgery waiting times are below provincial times, but are rising quickly
- Heart related procedure wait times are higher than Ontario times with the exception of angiography. Two of these services are not provided in Erie St. Clair (angioplasty, bypass surgery)
- Cataract surgery times are much lower than Ontario times
- 90% of Erie St. Clair LHIN patients have their total hip replacements performed in a shorter period of time than Ontario although the median wait time is slightly longer
- Total knee replacement median wait times are currently longer than Ontario times, while 90% of all knee replacements in the Erie St. Clair LHIN are performed in close to the same time frame as the province
- CT scanner times have always been longer than Ontario times
- CCAC times are generally lower than Ontario averages except for nursing which is the same as Ontario
- Average wait time to service initiation for Children's Treatment Centres are all over 90 days. They are longer than Ontario averages for occupational therapy and audiology. Audiology is not reported for Essex County

Non-Institutional Services Key Findings

- CCAC services are provided quickly across the Erie St. Clair LHIN. The creation of one CCAC will enhance system administration and coordination of effort between CCACs and their partners. Maintenance of policy flexibility at the local levels will be an ongoing challenge

- Community Support Services represent a small amount of money spread over a very large numbers of programs and are provided to a large number of agencies. Issues of efficiency, information creation and flow as well as system coordination will be challenges in this area
- The number of children seen by Children's Treatment Centres varies greatly from the proportions of children in each planning area. Data collection will need to be improved before comparative studies can be performed
- Substance abuse and problem gambling services are provided throughout the Erie St. Clair LHIN, but there are some key services that are not available. A very large number of Erie St. Clair residents go out of the area for care and travel beyond London

Utilization and Structure of the Health Care System Key Findings

- This is a very complex, extremely interrelated system
- Five organizations manage over $520M
- 52 organizations manage $17.4M
- The definition of Alternate Level of Care days is still being refined, however, 2005/06 work indicates that at least 78 acute care beds were used by patients not requiring acute hospital care
- There is considerable movement between planning areas and to London, except for substance abuse and problem gambling services
- A large number of substance abuse and problem gambling clients go beyond the Southwest LHIN for services. Very few non-Erie St. Clair LHIN residents come here for care
- Tertiary mental health is provided outside of Erie St. Clair and the system does not appear to be well connected
- Administration and back office changes are required. Information Technology continues to be a special need
- Navigation processes need to be improved
- New services are likely needed to provide continuity
- Expanded services are needed to optimize existing services
- Specialist and generalist physician supply is well below Ontario rates
- Supporting resources will be needed to attract and retain physicians
- Waiting times for selected procedures are not improving compared to Ontario wait times except for angioplasty, which has been the worst relative wait time procedure of those tracked
- Nurse supply is in decline

POPULATION CHARACTERISTICS

SECTION 1

This section will focus on the key characteristics of the population within the Erie St. Clair LHIN. These characteristics help to explain the current use of health care services and to predict future demand. The Erie St. Clair LHIN has a greater prevalence of some of the characteristics associated with greater health care need which will be highlighted in this summary. More information may be found in Appendix B: Health System Monitoring Report.

Population Structure by Age

The table below shows the 2006 estimated population by age groups. Overall, Erie St. Clair LHIN is 5% of the Ontario population. Essex County is home to over 3% of Ontario's residents, while Chatham-Kent and Lambton County hold about 1% each. Chatham-Kent and Lambton County have similar distribution of residents by age group and they are different from Essex County and Ontario. Chatham-Kent and Lambton County have fewer 15 to 44-year olds and more persons aged 65 years and over.

Estimated Popoulation by Age Group, 2006*

	Age Group						
Planning Area	**0-14**	**15-44**	**45-64**	**65-74**	**75-84**	**85+**	**Total**
Chatham-Kent	19,190	43,150	29,840	8,490	6,070	2,150	108,870
	18%	40%	27%	8%	6%	2%	100%
Essex	76,070	180,620	101,740	26,600	19,160	5,820	409,990
	19%	44%	25%	6%	5%	1%	100%
Lambton	21,570	51,000	38,140	11,200	7,880	2,420	132,200
	16%	39%	29%	8%	6%	2%	100%
ESC LHIN	116,830	274,770	169,720	46,290	33,110	10,390	651,060
	18%	42%	26%	7%	5%	2%	100%
Ontario	2,264,140	5,518,800	3,270,320	866,580	587,060	189,310	12,696,200
	18%	43%	26%	7%	5%	1%	100%

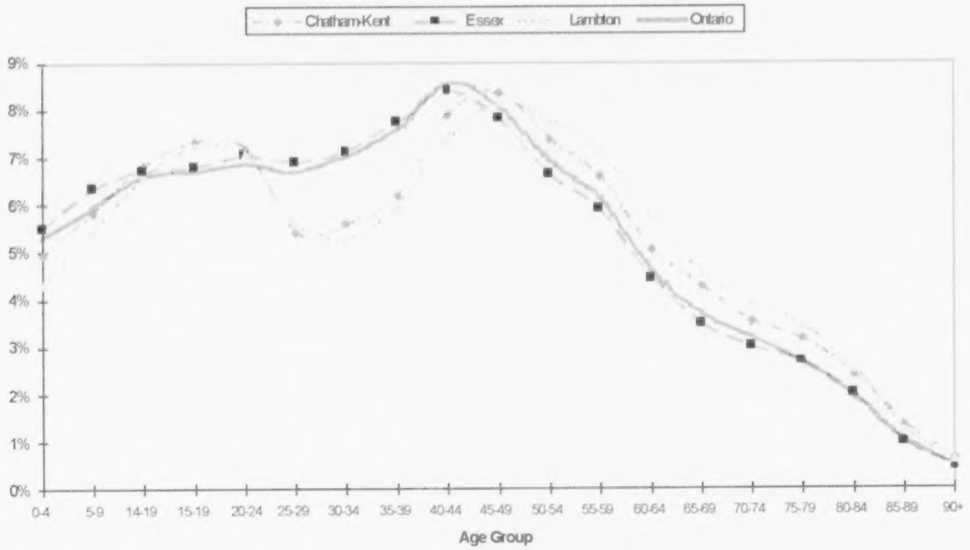
The chart below shows the percentage contribution to total population for each five-year age group in each planning area. The Erie St. Clair LHIN as a whole was removed to make the differences easier to see.

On the left side of the chart, one notes that the 0-4 year population in Lambton County is just over 4% of the total population of Lambton County, while for Chatham-Kent it is about 5%. For both Essex County and Ontario, the 0 - 4 year old population is about 5.5% of the total populations.

The key observations are, for Chatham-Kent and Lambton County, the very low percentage contributions by young adults between 25 and 44 and the higher than Ontario Essex County contributions by adults 50 and older. Essex County and Ontario age distributions are very similar to each other. The need for different types of health services, different prevention and promotion programs is reflected in the different age structures shown.

Five Year-age Groups, 2006*

As percentage of each PA



Population Projections

The tables below provide population estimates and projections for specific years only. The base year is 2006. The other years were chosen because they match utilization data time periods (between 2001 and 2005) or reflect the three-year IHSP horizon for LHIN's (2009) or the five and ten-year horizons generally used by the MOHLTC (2011, 2016). These numbers are used for all projections throughout this report. They are the most recent projections from the Ministry of Finance – the sole government-recognized source of population projections.

The table below shows the population figures used in this report by the commonly-used six age groups. For projections based on different age groupings, the same base data are used and adjusted to reflect the necessary age groupings (e.g. DATIS uses different age groups in their standard reports. However, the information used to create this table is used to create DATIS-compatible age groupings).

Population Census, Estimates and Projections, 2001 to 2016*

CHATHAM-KENT	0-14	15-44	45-64	65-74	75-84	85+	Total
2001	21,205	44,335	25,965	8,535	5,795	1,885	107,710
2002	20,814	44,221	26,751	8,504	5,869	1,939	108,093
2003	20,393	43,799	27,509	8,528	5,896	1,991	108,099
2004	19,470	42,423	29,025	8,896	5,806	2,095	107,703
2005	19,640	43,880	29,110	8,410	6,090	2,100	109,240
2006	19,190	43,150	29,840	8,490	6,070	2,150	108,870
2009	18,080	41,250	31,590	9,010	5,910	2,270	108,090
2011	17,540	40,390	32,180	9,490	5,830	2,370	107,800
2016	17,090	39,050	31,460	11,470	6,080	2,440	107,570

ESSEX	0-14	15-44	45-64	65-74	75-84	85+	Total
2001	75,580	166,715	84,695	26,280	16,775	4,925	374,975
2002	75,760	169,854	88,154	26,315	17,311	5,046	382,441
2003	75,735	172,098	91,488	26,423	17,699	5,312	388,749
2004	75,411	175,094	99,719	27,891	17,908	6,124	402,155
2005	76,300	179,270	98,530	26,420	18,920	5,410	404,840
2006	76,070	180,620	101,740	26,600	19,160	5,820	409,990
2009	75,510	183,270	111,520	28,570	19,210	6,910	424,990
2011	74,940	185,450	117,450	30,340	19,240	7,470	434,880
2016	75,520	190,820	126,370	38,140	19,930	8,380	459,150

LAMBTON	0-14	15-44	45-64	65-74	75-84	85+	Total
2001	24,180	49,710	32,990	11,165	6,975	1,945	126,975
2002	23,693	50,198	34,065	11,134	7,181	2,029	128,301
2003	23,119	50,111	35,028	11,198	7,324	2,141	128,924
2004	21,871	49,124	36,682	11,879	7,414	2,492	129,462
2005	22,230	51,660	37,290	11,040	7,800	2,280	132,280
2006	21,570	51,000	38,140	11,200	7,880	2,420	132,200
2009	20,040	49,330	39,950	12,150	7,910	2,870	132,240
2011	19,240	48,580	40,480	13,010	7,960	3,150	132,390
2016	18,490	46,840	39,610	16,350	8,330	3,490	133,100

ESC LHIN	0-14	15-44	45-64	65-74	75-84	85+	Total
2001	120,965	260,760	143,650	45,980	29,545	8,755	609,660
2002	120,266	264,273	148,970	45,953	30,361	9,014	618,835
2003	119,247	266,009	154,025	46,149	30,919	9,443	625,773
2004	116,752	266,641	165,426	48,666	31,128	10,710	639,321
2005	118,170	274,810	164,930	45,870	32,810	9,790	646,360
2006	116,830	274,770	169,720	46,290	33,110	10,390	651,060
2009	113,630	273,850	183,060	49,730	33,030	12,050	665,320
2011	111,720	274,420	190,110	52,840	33,030	12,990	675,070
2016	111,100	276,710	197,440	65,960	34,340	14,310	699,820

*Ministry of Finance

ONTARIO	0-14	15-44	45-64	65-74	75-84	85+	Total
2001	2,232,750	5,005,840	2,699,270	818,170	503,930	150,070	11,410,045
2002	2,216,840	5,478,348	2,263,875	880,771	553,541	155,999	12,109,369
2003	2,215,375	5,481,906	2,273,023	881,099	554,514	160,746	12,122,621
2004	2,286,780	5,465,790	3,059,670	849,170	564,070	167,240	12,392,720
2005	2,273,670	5,494,240	3,169,720	858,930	577,650	176,660	12,550,870
2006	2,261,940	5,520,310	3,281,650	871,530	589,800	187,720	12,712,950
2009	2,238,950	5,577,470	3,601,320	946,250	613,130	220,070	13,197,190
2011	2,229,010	5,635,590	3,775,200	1,012,510	626,680	240,070	13,519,060
2016	2,277,190	5,794,280	3,994,800	1,289,180	675,160	280,320	14,310,930

The table above shows that the population of the Erie St. Clair LHIN is projected to rise to 699,820 by 2016, up from the estimated 651,060 in 2006. Chatham-Kent is the only community that is projected to have a population decline during the 2006 to 2016 period.

The table below shows the change in population by age group for each planning area between 2006 and 2016.

Population Estimates and Projections, 2006 to 2016*

As percentage change from 2006

CHATHAM-KENT	0-14	15-44	45-64	65-74	75-84	85+	Total
2006	100%	100%	100%	100%	100%	100%	100%
2009	94%	96%	106%	106%	97%	106%	99%
2011	91%	94%	108%	112%	96%	110%	99%
2016	89%	90%	105%	135%	100%	113%	99%

LAMBTON	0-14	15-44	45-64	65-74	75-84	85+	Total
2006	100%	100%	100%	100%	100%	100%	100%
2009	93%	97%	105%	108%	100%	119%	100%
2011	89%	95%	106%	116%	101%	130%	100%
2016	86%	92%	104%	146%	106%	144%	101%

ESSEX	0-14	15-44	45-64	65-74	75-84	85+	Total
2006	100%	100%	100%	100%	100%	100%	100%
2009	99%	101%	110%	107%	100%	119%	104%
2011	99%	103%	115%	114%	100%	128%	106%
2016	99%	106%	124%	143%	104%	144%	112%

ESC LHIN	0-14	15-44	45-64	65-74	75-84	85+	Total
2006	100%	100%	100%	100%	100%	100%	100%
2009	97%	100%	108%	107%	100%	116%	102%
2011	96%	100%	112%	114%	100%	125%	104%
2016	95%	101%	116%	142%	104%	138%	107%

ONTARIO	0-14	15-44	45-64	65-74	75-84	85+	Total
2006	100%	100%	100%	100%	100%	100%	100%
2009	99%	101%	110%	109%	104%	117%	104%
2011	99%	102%	115%	116%	106%	128%	106%
2016	101%	105%	122%	148%	114%	149%	113%

*Ministry of Finance Population Projections

The table above projects that although the Chatham Kent population will decrease about 1% over the time period, the decline is focused in the 0-44 year age groups. There will be a 35% increase in the 65-74 year age group. Lambton County is projected to increase by only 1% and Essex County by 12%, compared to Ontario's 13% increase. Chatham-Kent and Lambton County show similar patterns of increase (although Lambton County shows higher increases); while Essex County is more similar to Ontario except for the 75 - 84-year-olds in Essex County.

Erie St. Clair LHIN should plan for no change in population based demand for 0 - 44-year-olds, 16% increase in services for 45-64-year olds, and a 28% increase for 65+ year olds (this number is calculated separately and is not shown on the table).

Ethnicity

All of the following information is taken from Statistic Canada's 2001 Census

The table below shows that more Erie St. Clair LHIN residents tend to come from multiple ethnic origins compared to Ontarians.

Population by Ethnic Origin, 2001*

Planning Area	Total Population	Multiple Origins*	Single Origin
Chatham-Kent	105,850	46%	54%
Essex	371,085	41%	59%
Lambton	125,560	46%	54%
ESC LHIN	602,495	43%	57%
Ontario	11,285,550	39%	61%

* 2001 Census, Data Warehouse

The ethnic origin of the Erie St. Clair LHIN and its planning areas is heavily weighted to western European, eastern European and North American Indian. It is much less ethnically diverse than Ontario overall.

The Aboriginal population is referred to as "North American Indian" in Census records. The table below shows the numbers of persons who self report Aboriginal identity. The table shows that there are 2.56 times as many persons in Lambton County who consider themselves Aboriginal compared to Ontario overall. There is also a slightly higher percentage in Chatham-Kent (1.18 times more). Essex County has only 0.72 times as many self-reported Aboriginals as Ontario overall. It should be noted that some First Nations reserves in Lambton County (Kettle Point 44 and Walpole Island 46) have no data available due to incomplete enumeration or non

participation in the census but they likely represent substantial Aboriginal populations. Although Walpole Island is part of Lambton County, the majority of these residents seek their health care in Chatham-Kent.

Self-Perception of Aboriginal Identity, 2001*

	Total Aboriginal identity population		North American Indian single response		Métis single response		Inuit single response		Multiple Aboriginal responses		Aboriginal responses not included elsewhere	
Planning Area	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Chatham-Kent	2,080	2.0%	1,465	1.4%	575	0.5%	-	0.0%	10	0.0%	40	0.0%
Essex	4,450	1.2%	2,790	0.8%	1,405	0.4%	25	0.0%	95	0.0%	135	0.0%
Lambton	5,370	4.3%	4,630	3.7%	635	0.5%	15	0.0%	25	0.0%	55	0.0%
ESC LHIN	11,900	2.0%	8,885	1.5%	2,615	0.4%	40	0.0%	130	0.0%	230	0.0%
Ontario	188,315	1.7%	131,560	1.2%	48,340	0.4%	1,375	0.0%	1,695	0.0%	5,345	0.0%

As ratio to Ontario Percentages

Planning Area	Total Aboriginal identity population	North American Indian single response	Métis single response	Inuit single response	Multiple Aboriginal responses	Aboriginal responses not included elsewhere
Chatham-Kent	1.18	1.19	1.27	0.00	0.63	0.80
Essex	0.72	0.64	0.88	0.55	1.70	0.77
Lambton	2.56	3.16	1.18	0.98	1.33	0.92
ESC LHIN	1.18	1.27	1.01	0.54	1.44	0.81
Ontario	1.00	1.00	1.00	1.00	1.00	1.00

*2001 Census, Data Warehouse

Immigration

The table below shows the number and percentage of residents by the time period of their immigration to Canada. The Erie St. Clair LHIN has only 0.65 times as many immigrants as Ontario. Chatham-Kent has only about a third (0.35) times as many immigrants as Ontario and Lambton County only 0.43 times as many. Of the immigrants to all planning areas, the majority immigrated prior to 1970, however, Chatham-Kent and Lambton County have had less immigration since that time. Essex County has more closely mirrored Ontario's immigration periods. In fact, there was an increase in recent immigrants into Essex County.

Immigrants by Period of Immigration, 2001*

	Immigrants		Before 1961		1961-1970		1971-1980		1981-1990		1991-1995		1996-2001	
Planning Area	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Chatham-Kent	10,085	10%	3,800	3.6%	1,540	1.5%	1,650	1.6%	1,535	1.5%	800	0.8%	760	0.7%
Essex	79,775	21%	15,930	4.3%	12,615	3.4%	11,490	3.1%	12,860	3.5%	10,915	2.9%	15,965	4.3%
Lambton	14,515	12%	6,015	4.8%	2,860	2.3%	2,490	2.0%	1,665	1.3%	710	0.6%	775	0.6%
ESC LHIN	104,375	17%	25,745	4.3%	17,015	2.8%	15,630	2.6%	16,060	2.7%	12,425	2.1%	17,500	2.9%
Ontario	3,030,080	27%	502,735	4.5%	427,795	3.8%	496,680	4.4%	580,495	5.1%	483,635	4.3%	538,735	4.8%

As ratio to Ontario Percentages

Planning Area	Immigrants	Before 1961	1961-1970	1971-1980	1981-1990	1991-1995	1996-2001
Chatham-Kent	0.35	0.81	0.38	0.35	0.28	0.18	0.15
Essex	0.80	0.96	0.90	0.70	0.67	0.69	0.90
Lambton	0.43	1.08	0.60	0.45	0.26	0.13	0.13
ESCLHIN	0.65	0.96	0.75	0.59	0.52	0.48	0.61

*2001 Census, Data Warehouse

The table below shows the number of residents by generation in Canada. The table shows that Erie St. Clair LHIN and Chatham-Kent and Lambton County in particular are composed of longer-term Canadians than Ontario overall. 1.5 times as many Chatham-Kent residents are third generation or more, compared to Ontario. In terms of first generation Canadians, Chatham-Kent and Lambton County have only 0.36 to 0.44 times as many residents as Ontario overall. Essex County more closely reflects Ontario's generation pattern, but it is weighted towards second and higher generations than Ontario overall.

Resident Generation, 2001*

Planning Area	1st generation		2nd generation		3rd generation and over	
Chatham-Kent	9,935	12%	14,495	17%	60,160	71%
Essex	77,360	26%	61,260	21%	156,790	53%
Lambton	14,485	14%	18,680	18%	68,020	67%
ESC LHIN	101,780	21%	94,435	20%	284,970	59%
Ontario	2,951,230	33%	1,808,580	20%	4,288,230	47%

As ratio to Ontario Percentages

Planning Area	1st generation	2nd generation	3rd generation and over
Chatham-Kent	0.36	0.86	1.50
Essex	0.80	1.04	1.12
Lambton	0.44	0.92	1.42
ESC LHIN	0.65	0.98	1.25
Ontario	1.00	1.00	1.00

*2001 Census, Data Warehouse

Language

Census data provide three types of information related to languages – mother tongue, knowledge, home and work use. Each provides a slightly different insight into access and community engagement.

The table below examines mother tongue of residents. Almost all residents in all areas reported only one language as their mother tongue. English is the mother tongue for 71% of Ontarians but 79% (1.12 times as many) Erie St. Clair LHIN residents. Both Chatham Kent and Lambton County have proportionately more residents (1.24 to 1.27 times as many) whose mother tongue was English. There are smaller percentages of persons whose mother tongue was French or a non official language.

Mother Tongue, 2001*

	Single responses		English		French		Non-official languages	
Planning Area	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Chatham-Kent	105,110	99%	92,555	87%	3,565	3%	8,985	8%
Essex	365,910	99%	269,985	73%	14,300	4%	81,625	22%
Lambton	124,620	99%	112,965	90%	2,570	2%	9,085	7%
ESC LHIN	595,640	99%	475,505	79%	20,435	3%	99,695	17%
Ontario	11,122,940	99%	7,965,225	71%	485,630	4%	2,672,085	24%

As ratio to Ontario Percentages

Planning Area	Single responses	English	French	Non-official languages
Chatham-Kent	1.01	1.24	0.78	0.36
Essex	1.00	1.03	0.90	0.93
Lambton	1.01	1.27	0.48	0.31
ESC LHIN	1.00	1.12	0.79	0.70
Ontario	1.00	1.00	1.00	1.00

*2001 Census Data Warehouse

The table below examines knowledge of an official language by planning area. Only 1.2% of Erie St. Clair LHIN residents have no knowledge of either English or French. This is only 0.58 of the Ontario percentage. The percentage of residents who understand only French is only 0.1% of Erie St. Clair LHIN – 0.36 times the Ontario percentage. The challenge will be to meet the needs of these two small-volume groups because their needs may not be publicly well-known.

Knowledge of an Official Language, 2001*

	English only		French only		English and French		Neither English nor French	
Planning Area	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Chatham-Kent	97,775	92%	85	0.1%	7,505	7%	490	0.5%
Essex	326,445	88%	610	0.2%	37,640	10%	6,395	1.7%
Lambton	116,635	93%	115	0.1%	8,445	7%	370	0.3%
ESC LHIN	540,855	90%	810	0.1%	53,590	9%	7,255	1.2%
Ontario	9,690,745	86%	42,305	0.4%	1,319,715	12%	232,780	2.1%

As ratio to Ontariio Percentages

Planning Area	English only	French only	English and French	Neither English nor French
Chatham-Kent	1.08	0.21	0.61	0.22
Essex	1.02	0.44	0.87	0.84
Lambton	1.08	0.24	0.58	0.14
ESC LHIN	1.05	0.36	0.76	0.58
Ontario	1.00	1.00	1.00	1.00

*2001 Census, Data Warehouse

The table below examines language spoken at home. Eighty-four percent of Erie St. Clair LHIN residents speak only English at home. Eight percent speak neither official language at home. A modest 0.4% speak only French at home. The remainder speak either official language and at least one other language. Because the non-English volumes are so small in Chatham-Kent and Lambton County, special effort will be required to ensure access and community engagement mechanisms are in place for non-English speaking persons.

Language Spoken at Home, 2001*

	Single Language				Single or Multiple Languages	
	English		French		Non-official	
Planning Area	**Number**	**%**	**Number**	**%**	**Number**	**%**
Chatham-Kent	97,495	92%	350	0.3%	2,665	2.5%
Essex	291,570	79%	1,840	0.5%	42,720	11.5%
Lambton	117,745	94%	440	0.4%	2,820	2.2%
ESC LHIN	506,810	84%	2,630	0.4%	48,205	8.0%
Ontario	8,456,585	75%	164,550	1.5%	1,321,980	11.7%

As ratio to Ontario Percentages

	Single Language		Single or Multiple Languages
Planning Area	**English**	**French**	**Non-official**
Chatham-Kent	1.23	0.23	0.23
Essex	1.05	0.34	0.84
Lambton	1.25	0.24	0.12
ESC LHIN	1.12	0.30	0.58
Ontario	1.00	1.00	1.00

*2001 Census, Data Warehouse

The table below examines languages spoken at work. Less than 1% of workers do not speak English at work. Workplace programs (both service and engagement) will capture virtually all employees if presented in English.

Languages Spoken at Work, 2001*

	English		French		Non-official languages		French and non-official language	
Planning Area	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Chatham-Kent	58,395	97%	70	0.1%	50	0.1%	-	0.0%
Essex	193,825	93%	580	0.3%	1,900	0.9%	20	0.0%
Lambton	67,825	98%	130	0.2%	25	0.0%	-	0.0%
ESC LHIN	320,045	95%	780	0.2%	1,975	0.6%	20	0.0%
Ontario	5,787,225	89%	31,935	0.5%	59,010	0.9%	710	0.0%

As ratio on Ontario Percentages

Planning Area	**English**	**French**	**Non-official languages**	**French and non-official language**
Chatham-Kent	1.09	0.24	0.09	-
Essex	1.05	0.57	1.01	0.88
Lambton	1.10	0.38	0.04	-
ESC LHIN	1.07	0.47	0.65	0.54
Ontario	1.00	1.00	1.00	1.00

*2001 Census, Data Warehouse

Income

Although much of the health care system is funded by taxes, there are transportation, drug, housing and other issues that affect health status and are related to income. The ICES Report on Primary Care in Ontario second installment (July 2006) found that: "People with low SES (socio-economic status, which is primarily related to income) and those with unmet health needs have the worst health status." and "Across Ontario, low income respondents were 2.4 times more likely to have rated their health as fair or poor than those with high incomes."

The table below examines average employment income by gender and by full and part-time work. The arrows indicate whether the average income is significantly different from the Ontario average with 95% confidence. For example, in Essex County, the upward arrow indicates that the average full-time male income is significantly higher than Ontario. The downward arrow for part-time females in Lambton County indicates that the average income in this cell is significantly lower than Ontario's. The chart shows that Chatham-Kent and Lambton County incomes for all categories are significantly lower than Ontario, while Essex County was significantly higher in all categories except part-time females where it was not significantly different from Ontario's average.

Average Employment Income, 2000*

Arrows represent significant difference compared to Ontario (95% CI)

	Full-Time				Part-Time			
	Male		Female		Male		Female	
Planning Area	Number	Sign. Diff.	Number	Sign. Diff.	Number	Sign. Diff.	Number	Sign. Diff.
Chatham-Kent	$ 46,082	↓	$ 32,761	↓	$ 22,007	↓	$ 14,741	↓
Essex	$ 56,449		$ 35,756	↓	$ 28,755		$ 17,079	
Lambton	$ 51,531	↓	$ 31,998	↓	$ 24,076	↓	$ 14,424	↓
ESC LHIN	$ 53,736	n.a.	$ 34,507	n.a.	$ 26,483	n.a.	$ 16,064	n.a.
Ontario	$ 53,923		$ 37,720		$ 25,139		$ 17,347	

*2001 Census, Data Warehouse

The table below examines source of income by planning area. 1.12 times as many Erie St. Clair LHIN residents receive their income from government transfers (e.g. Child Tax Credit, Old Age Security, GIS, GWA, EI, CPP), but the rates are 1.34 and 1.28 times higher in Chatham-Kent and Lambton County. The percent of persons not gaining income from employment also suggest isolation from community and for working age persons, lowered self esteem.

Composition of Income, 15 years and older, 2000*

Number and Percentages

	Employment Income		Government Transfer		Other	
Planning Area	Number	%	Number	%	Number	%
Chatham-Kent	60,587	74.5	10,654	13.1	10,084	12.4
Essex	223,237	79.9	27,381	9.8	28,498	10.2
Lambton	69,968	72.6	12,047	12.5	14,360	14.9
ESC LHIN	353,863	77.4	50,042	10.9	52,909	11.6
Ontario	6,767,067	78.7	842,659	9.8	988,834	11.5

As ratio to Ontario Percentages

Planning Area	Employment Income	Government Transfer	Other
Chatham-Kent	0.95	1.34	1.08
Essex	1.02	1.00	0.89
Lambton	0.92	1.28	1.30
ESC LHIN	0.98	1.12	1.01
Ontario	1.00	1.00	1.00

*2001 Census, Data Warehouse

The table below examines family incomes by family type. The table repeats the indications seen in the table above; that average incomes for families (whether married couples, common-law, or lone parents are significantly lower in Chatham-Kent and Lambton County than they are in Ontario. Essex County is not significantly different from Ontario.

Average Family Incomes by Family Type, 2000*

	Census Families		Married Couples		Common-Law Couples		Male Lone Parent		Female Lone Parent	
Planning Area	Number	Sign. Diff.	Number	Sign. Diff.	Number	Sign. Diff.	Number	Sign. Diff.	Number	Sign. Diff.
Chatham-Kent	$ 64,754	↓	$ 71,461	↓	$ 56,738	↓	$ 46,141	↓	$ 32,354	↓
Essex	$ 74,191		$ 81,555		$ 70,084		$ 57,404		$ 37,733	
Lambton	$ 67,245	↓	$ 73,881	↓	$ 57,283	↓	$ 51,103		$ 31,577	↓
ESC LHIN	71,032		78,107		64,516		54,139		35,694	
Ontario	73,849	n.a	81,221	n.a	68,295	n.a	53,326	n.a	38,110	n.a

*2001 Census, Data Warehouse

The table below shows the incidence of low income [a statistical value that represents the spending of 20 percentage points more than what the average local person/family spends on basic necessities (food shelter and clothing)]. It varies by year, by family size, urbanization and consumer price index. It is the best indicator of insufficient income.

Percentage of Low Income by Living Arrangement, 2000*

	All Private Households		Economic Families		Unattached Individuals	
Planning Area	Number**	%	Number**	%	Number**	%
Chatham-Kent	13,300	13	3,030	10	4,200	33
Essex	45,485	12	10,105	10	13,825	32
Lambton	14,165	12	3,165	9	4,580	31
ESC LHIN	72,950	12	16,300	10	22,605	32
Ontario	1,611,505	14	364,320	12	445,705	34

**based on percent and number of households by type

As ratio to Ontario Percentages

Planning Area	All Private Households	Economic Families	Unattached Individuals
Chatham-Kent	0.88	0.85	0.97
Essex	0.86	0.84	0.94
Lambton	0.81	0.76	0.92
ESC LHIN	0.85	0.82	0.94
Ontario	1.00	1.00	1.00

* 2001 Census, Data Warehouse

The table shows that although Chatham-Kent and Lambton County have significantly lower incomes than Ontario, the low income rates for families and individuals is proportionately less than Ontario and that economic families (this includes people living together and families sharing income but not necessarily parent and children living in parent's housing) are only 0.82 times as likely to be low income than Ontario overall.

Education Level

Appreciation of education levels is very important in the design of educational and instructional materials (such as health promotion and illness prevention packages) and mechanisms to ensure community engagement. Lower education levels are also related to low income. The table below examines education levels by planning area. Chatham-Kent in particular shows lower education levels than all other areas. Chatham-Kent residents are 1.28 times more likely to have less than a Grade 9 education than other Ontarians. They are only half as likely to have some university education. Essex County residents are 1.12 times more likely to have less than Grade 9 education. Lambton County is unique in that its residents are 0.82 times less likely to have less than Grade 9 education. However, all planning areas and the Erie St. Clair LHIN has higher proportions of only some high school or high school graduation and 1.11 times as likely to have only partial high school. Materials and processes aimed at high school graduates are likely to be unsuccessful for 55% of Erie St. Clair LHIN residents. Materials aimed at persons with Grade 9 will likely be unsuccessful for 10% of Erie St. Clair LHIN. However, they may also be inappropriate for the 43% of Erie St. Clair LHIN residents with at least some college or university.

Schools are excellent locations for program delivery. They are learning environments and change is the norm. Table 4.1.7(b) examines school attendance for 15 to 24-year-olds. Overall, 15 to 24-year-olds in Erie St. Clair LHIN are 1.1 times more likely not to be in school, with Chatham-Kent young adults being 1.2 times more likely not to be in school. Programs provided in schools will miss larger than expected numbers of young adults unless alternative delivery sites are chosen.

School Attendance, 15 to 24-year-olds, 2001*

Numbers and Percentages

	Not attending school		Attending school full time		Attending school part time	
Planning Area	**Number**	**%**	**Number**	**%**	**Number**	**%**
Chatham-Kent	6,120	42%	7,780	54%	635	4%
Essex	19,465	38%	28,280	56%	2,880	6%
Lambton	6,275	37%	9,985	59%	640	4%
ESC LHIN	31,860	39%	46,045	56%	4,155	5%
Ontario	520,035	35%	883,020	60%	76,625	5%

As ratio to Ontario Percentages

Planning Area	Not attending school	Attending school full time	Attending school part time
Chatham-Kent	1.20	0.90	0.84
Essex	1.09	0.94	1.10
Lambton	1.06	0.99	0.73
ESC LHIN	1.10	0.94	0.98
Ontario	1.00	1.00	1.00

*2001 Census, Data Warehouse

Labour Force Activity

Involvement in the workforce affects income, sense of community belonging, need for services and alters access to services.

The table below examines participation in the labour force. About two-thirds of the 15 years and over population across all planning areas report being in the labour force; that is either working or looking for work. Of all persons 15 years and over, Chatham-Kent and Lambton County show slightly lower employment percentages (60%) but the differences are minor – 0.96 times the Ontario rate. There are larger differences in the unemployment rate – the number of persons who are looking for work but cannot find it. Chatham-Kent residents are 1.35 times more unemployed than Ontarians and Lambton County is 1.08 times more unemployed.

Employment Characteristics, 2001*

All persons aged 15 years and over

	In the labour force		Employed		Unemployed	
Planning Area	Number	%	Number	%	Number	%
Chatham-Kent	55,745	66	51,125	60	4,620	8.3
Essex	195,515	66	183,910	62	11,600	5.9
Lambton	64,655	64	60,385	60	4,265	6.6
ESC LHIN	315,915	66	295,420	61	20,485	6.5
Ontario	6,086,815	67	5,713,900	63	372,915	6.1

As ratio to Ontario percentages

Planning Area	In the labour force	Employed	Unemployed
Chatham-Kent	0.98	0.96	1.35
Essex	0.98	0.99	0.97
Lambton	0.95	0.95	1.08
ESC LHIN	0.98	0.97	1.06
Ontario	1.00	1.00	1.00

*2001 Census, Data Warehouse

Family Structure

Family life is the core of individual and community life. Difficult family situations impact all aspects of daily life including health. The potential for higher social isolation among widowed and divorced persons may create poorer sense of general health and lower sense of community belonging – both factors related to relative need for health services, including prevention.

The table below examines family status of persons aged 15 years and over. Chatham-Kent has 1.09 times higher rate of divorced persons than Ontario and a very high 1.25 times as many widowed persons as Ontario. Lambton County has 1.19 times as many widowed persons as Ontario. Essex County has 0.79 times rate of separation than Ontario – potentially a positive sign.

Marital Status, 2001*

	Never legally married (single)		Legally married (and not separated)		Separated, but still legally married		Divorced		Widowed	
Planning Area	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Chatham-Kent	23,830	28%	46,635	54%	3,065	4%	6,145	7%	6,825	8%
Essex	89,030	30%	162,090	54%	8,075	3%	20,395	7%	19,795	7%
Lambton	27,230	26%	57,420	56%	3,715	4%	6,715	7%	7,710	8%
ESC Lhin	140,090	29%	266,145	54%	14,855	3%	33,255	7%	34,330	7%
Ontario	2,793,080	30%	4,897,095	53%	311,385	3%	597,595	7%	578,150	6%

As ratio to Ontario Percentages

Planning Area	Never legally married (single)	Legally married (and not separated)	Separated, but still legally married	Divorced	Widowed
Chatham-Kent	0.91	1.01	1.04	1.09	1.25
Essex	0.98	1.01	0.79	1.05	1.05
Lambton	0.87	1.05	1.07	1.00	1.19
ESC Lhin	0.94	1.02	0.90	1.05	1.12
Ontario	1.00	1.00	1.00	1.00	1.00

*2001 Census, Data Warehouse

The table below examines lone-parent led families by parent gender. Earlier information showed that family income was lower in lone parent led families and lower still in female versus male led families. Essex County has slightly higher rates of lone parent-led families than Ontario, while Chatham-Kent and Lambton County had lower rates. Lambton County had the low ratio of female lone parent-led families – only 0.85 times the Ontario rate, while Chatham-Kent was 0.93 times Ontario's rate. Chatham-Kent and Lambton County male lone parent-led families were only 0.85/0.86 times the Ontario rate.

Lone Parent-Led Families, 2001*

	Female parent		Male parent		Combined		All families	
Planning Area	Number	%	Number	%	Number	%	Number	%
Chatham-Kent	3,555	12	1,945	6	5,500	18	30,485	100
Essex	13,740	13	8,300	8	22,040	21	104,610	100
Lambton	3,920	11	2,310	6	6,230	17	36,745	100
ESC LHIN	21,215	12	12,555	7	33,770	20	171,840	100
Ontario	401,245	13	236,010	7	637,255	20	3,190,990	100

As ratio to Ontario percentages

Planning Area	Female parent	Male parent	Combined
Chatham-Kent	0.93	0.86	0.90
Essex	1.04	1.07	1.05
Lambton	0.85	0.85	0.85
ESC LHIN	0.98	0.99	0.98
Ontario	1.00	1.00	1.00

*2001 Census, Data Warehouse

The table below examines the average income per family member by family type. A person's age and family position affects their need for income – for example, a five year olds need for clothing is not as high as a working adult's. However, large variations in income per family member may indicate more or less straitened circumstances. The table below uses the Ontario per family member average income as the ratio (highlighted cell). All other values are adjusted to this figure. This table reinforces earlier discussion on income levels for all families but now controls for family size. Regardless of the caveat noted earlier in this paragraph, the fact that per capita income in female-led families in Chatham-Kent and Lambton County was only 0.47/0.48 of the Ontario married couple per capita income is a stark factor. Male lone parent-led family income is very similar to common-law families and both are lower than married couples. This pattern holds for all geographies.

Average Income per Person by Family Type, 2000*

	All Families		Married Couples		Common-law		Female Lone-Parent		Male Lone-Parent	
Planning Area	Number	Ratio**	Number	Ratio**	Number	Ratio**	Number	Ratio**	Number	Ratio**
Chatham-Kent	$ 21,698	0.84	$ 23,241	0.90	$ 19,580	0.76	$ 12,297	0.47	$ 20,180	0.78
Essex	$ 24,434	0.94	$ 25,654	0.99	$ 25,733	0.99	$ 14,880	0.57	$ 23,602	0.91
Lambton	$ 22,743	0.88	$ 24,246	0.93	$ 20,452	0.79	$ 12,335	0.48	$ 20,903	0.81
ESC LHIN	$ 23,467	0.90	$ 24,675	0.95	$ 23,789	0.92	$ 13,984	0.54	$ 22,117	0.85
Ontario	$ 24,533	0.95	$ 25,933	1.00	$ 24,601	0.95	$ 14,909	0.57	$ 22,134	0.85

*2001 Census, Data Warehouse

**Ratio to Ontario Married Couples

The table below examines living arrangements of persons aged 65 years and over. The need for home support services increases dramatically over 65, but one of the admission criteria for home service is in home family support. Those living alone are at increased risk of institutional placement. Often associated with living alone is social isolation, poor housing state, poor nutrition, etc. Chatham-Kent elderly are 1.26 times more likely to live alone than Ontarians overall. The Essex County and Lambton County are also higher by 1.10/1.12 times. These figures indicate there will be more demand and more challenge for senior's health in Erie St. Clair LHIN.

Living Arrangements of Seniors, 2001

	Persons 65 yrs and over		Living in a Family		Living with relatives		Living with non-relatives only		Living alone	
Planning Area	Number	%**	Number	%	Number	%	Number	%	Number	%
Chatham-Kent	14,810	14%	9,295	63%	390	3%	125	1%	5,000	34%
Essex	44,940	12%	29,260	65%	1890	4%	500	1%	13,285	30%
Lambton	18,955	15%	12,670	67%	420	2%	165	1%	5,700	30%
ESC LHIN	78,705	13%	51,225	65%	2,700	3%	790	1%	23,985	30%
Ontario	1,379,970	12%	905,390	66%	84,505	6%	20,525	1%	369,550	27%

** percent of total population

As ratio to Ontario Percentages

Planning Area	Persons 65 yrs and over	Living in a Family	Living with relatives	Living with non-relatives only	Living alone
Chatham-Kent	1.14	0.96	0.43	0.57	1.26
Essex	0.99	0.99	0.69	0.75	1.10
Lambton	1.23	1.02	0.36	0.59	1.12
ESC LHIN	1.00	1.00	1.00	1.00	1.00
Ontario	1.07	0.99	0.56	0.67	1.14

Housing

Housing ownership is an indirect measure of community belonging, income, family stability and may have an impact on diseases associated with poor housing (respiratory issues are pre-eminent). Suitable housing is also a precondition for in home services. The table below examines home renter/owner/band status. Home ownership is higher in all three Erie St. Clair LHIN planning areas than it is across Ontario, ranging from 1.06 in Chatham-Kent to 1.11 in Lambton County. The reported Band housing numbers are low, but are almost twice the Ontario rate in Lambton County (1.97 times). The known undercount of Walpole Island 46 and Kettle Point 47 will increase the numbers and ratios for Lambton County.

Housing Ownership, 2001*

	Owned		Rented		Band housing	
Planning Area	Number	%	Number	%	Number	%
Chatham-Kent	30,370	72	11,700	28	15	0.0
Essex	103,130	73	38,170	27	-	0.0
Lambton	37,775	75	12,255	24	135	0.3
ESC LHIN	171,275	73	62,125	27	150	0.0
Ontario	2,862,295	68	1,351,365	32	5,750	0.0

As ratio to Ontario percentages

Planning Area	Owned	Rented	Band housing
Chatham-Kent	1.06	0.87	0.26
Essex	1.08	0.84	0.00
Lambton	1.11	0.76	1.97
ESC LHIN	1.08	0.83	0.47
Ontario	1.00	1.00	1.00

*2001 Census, Data Warehouse

The table below examines housing condition in the planning areas. Housing condition in Erie St. Clair LHIN is better than Ontario overall due to better than Ontario housing conditions in Essex County. Chatham-Kent and Lambton County housing conditions are quite similar to Ontario overall.

Housing Condition, 2001*

	Regular maintenance only		Minor repairs		Major repairs	
Planning Area	Number	%	Number	%	Number	%
Chatham-Kent	28,105	67	10,820	26	3,160	8
Essex	101,440	72	30,550	22	9,305	7
Lambton	33,270	66	13,050	26	3,850	8
ESC LHIN	162,815	70	54,420	23	16,315	7
Ontario	2,830,380	67	1,074,735	25	314,300	7

As ratio to Ontario percentages

Planning Area	Regular maintenance	Minor repairs	Major repairs
Chatham-Kent	1.00	1.01	1.01
Essex	1.07	0.85	0.88
Lambton	0.99	1.02	1.03
ESC LHIN	1.04	0.91	0.94
Ontario	1.00	1.00	1.00

*2001 Census Data Warehouse

Population Characteristics

- Compared to Ontario, a higher percentage of the population of the Erie St. Clair LHIN are age 65 and over – the highest proportions of the population in this age group are in Chatham-Kent and Lambton County
- Essex County has a higher proportion of young people (aged 0 – 14 years) than Chatham-Kent and Lambton County as well as Ontario
- The population of Erie St. Clair LHIN is projected to grow over the next 5 – 10 years, with the exception of Chatham-Kent which is projected to show slight decline
- Erie St. Clair has a slightly higher proportion of Aboriginals than Ontario
- There is a lower proportion of recent immigrants in Erie St. Clair with the exception of Essex County which has a similar rate to the province
- Average incomes for all family types are significantly lower in Chatham-Kent and Lambton County compared to Ontario

APPENDIX B

HEALTH SYSTEM MONITORING REPORT

HEALTH SYSTEM MONITORING REPORT

APPENDIX B

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Introduction

The Erie St. Clair Local Health Integration Network (ESC LHIN) used the 2004 Health System Monitoring Report prepared by the former Essex, Kent and Lambton District Health Council as a basis for the Integrated Health Service Plan (IHSP) Environmental Scan.

This report is an update of that document with the most recent information available at the time of printing. Tables have been updated where possible; some new sections have been added including Children's Treatment Centres, selected Drug and Addictions agencies, wait times for priority programs and future service level projections based on population projections. Some tables have been eliminated where reliable comparable information could not be provided within the prescribed timelines.

Of particular significance in the preparation of this report is that the wide range of agencies' representatives who had been involved in previous years were not included in this report, nor has the information been reviewed by them. The interpretations are those of the authors only.

Every attempt is made to present the information at five geographic levels – Ontario, Erie St. Clair LHIN (ESC LHIN), Chatham Kent, Essex and Lambton. This will allow informed comparable discussions for each Planning Area. As well, comparisons of ESC LHIN and the three Planning Areas to Ontario are provided where they are meaningful. This allows the reader to see not only volumes and percentages, but also to see how the percentages compare to Ontario. In the absence of formally set benchmarks (such as those for wait times), the reader will see how each Planning Area compares to Ontario. The Ontario estimates should not be considered the ideal or target, since these rates are simply the average of the "best" and "worst" rates in the province. There is however some data in the report that are currently validated only at the LHIN and Ontario level at the time of printing.

The information presented is taken from a number of sources and is taken from various time periods, ranging from 2001 Census to 2005/06 service records. In all cases, the best available information is presented. Some general caveats must be noted:

- It is not the intent of the document to present exhaustive information on the health care system in ESC LHIN. Of necessity, important information is excluded. It is expected (and is in fact necessary) that implementation and monitoring activities must include all practical and relevant information. This report is indicative only
- The variety of data sources results in differences in reliability of the data. For example, self reports of health and disease (Section 4: Population Health) will not provide consistent information. Individuals' perceptions of health and illness are not always congruent with reported illness. In some cases, knowing that there is inconsistency between data sets is very helpful in determining new approaches to service. In some cases,

it provides conflicting information that needs to be reconciled before implementation decisions are made. Important inconsistencies will be pointed out in the ensuing discussions

- Reporting systems are evolving. The Ministry of Health and Long Term Care (MOHLTC) is in the midst of a major upgrading in the amount and comparability of data collected and information provided for monitoring and decision-making. Some collection and interpretation processes are quite stable (most hospital reporting), while new systems are being implemented for some agencies. It is normal to expect apparently unreasonable variations between reporting periods as new information processes are brought into use. Again, it is necessary to verify key information prior to making implementation decisions
- Limited high level trending data are presented. In some cases, there are technical reasons for inconsistencies while in others there are simply planning resource limitations. Any good implementation process will include trend data. This is an initial planning document only

As in previous years, the report is organized according to four key themes. The "Population Health" section includes morbidity and mortality indicators, information on the use of screening and preventive services, and on the incidence and prevalence of various health conditions and risk factors. The "Health Services Utilization" section monitors changes in the utilization of local services and of services across Ontario by local residents. This section includes utilization of emergency services, hospital sectors, community and long term care services. The "Structure of the Health Care System" section identifies specific structural aspects of the ESC LHIN's health care system including numbers of providers, the number of hospital and long term care beds, inventory of services and levels of base funding. These indicators identify system resources to address population needs. The "Population Characteristics" describes the demographic character of the population. Included are factors such as age, income, education level, etc. that influence health status. Key observations are noted in each section where applicable.

Methodological Issues and Limitations: For information on the analysis and interpretation of each indicator, please read the definitions and limitations carefully. Since the report continues to evolve according to changes in data availability, please note that the 2005/06 report is not directly comparable to the previous Health System Monitoring Reports. Information from new data sources may contain flaws that will only be apparent when the key data persons responsible for the new data review their numbers. Revisions to data are to be expected when new systems are established. Readers are encouraged to contact the ESC LHIN if they notice inaccuracies in their data. Future revisions and all planning decisions will reflect updated information.

Limited information on the capacity and utilization of inpatient Rehabilitation and Complex Continuing Care (CCC) is included in this report, partially due to technical issues, partially due to resource constraints; however, additional information will be included in further updates following consultation with providers in the Erie St. Clair LHIN.

Tertiary mental health information is limited to regional mental health care at the London and St. Thomas sites, while out-patient mental health and community mental health information is not available for this report. However, with changes in the reporting systems for Community Mental Health Agencies, it is anticipated that utilization information will be available for future reports.

This report will evolve over time and it is anticipated that future reports will include information on other community agencies including Community Health Centres and ambulatory services in general.

POPULATION HEALTH

SECTION 1

1.1 Mortality

Definition

- Annual all cause age standardized mortality rates (ASMR) for males and females per 100,000 population
- Annual ASMR for select leading causes of death per 100,000 population
- Leading causes of death as a percentage of all deaths

Significance/Uses

- Mortality statistics are an objective indicator of health status
- Useful in planning health services and in determining priority health problems. Useful for setting and assessing achievement of health objectives
- Mortality is the upper limit of the disease severity. Although deaths are not completely avoidable, a sudden increase in rates should be a warning sign that the quality of care may need to be improved
- Comparison over time and place

Limitations

- Reflects only fatal diseases and does not provide information on the prevalence of disease and particularly for conditions unlikely to cause death
- Differences in reporting methods may affect comparison over place and time
- Rates vary by age, sex, socioeconomic status (SES) etc. Rates should be standardized to enable comparisons over time and between populations; however, crude rates provide the best description of local experience
- Rates are based on three consecutive years of death data, summed and divided by three. The average number is then divided by the population estimate of the middle year. The reference period of these data reflects the mid point of the three-year period. Rates are age standardized using the direct method and the 1991 Canadian Census Population structure. ESC LHIN numbers were derived from Essex, Kent and Lambton District Health Council in the Health Indicators report
- In 2000 the Registrar General adopted ICD-10 for coding causes of death. ICD 10 is more detailed than ICD-9, with approximately 3,000 additional diagnostic categories. Thus causes of death coded using ICD-9

and ICD-10 are not directly comparable. For 2000-2001, the leading causes are based on codes for a subset of the "List of 113 Selected Causes of Death" developed by the National Center for Health Statistics in the US, which are comparable to codes used for the ICD-9 leading categories. For more information on ICD-10 and causes of death see "Comparability of Cause of Death Between ICD-9 and ICD-10: Preliminary Estimates." www.cdc.gov/nchs/products/pubs/pubd/nvsr/49/49-13.htm

- Due to changes in coding, trends over time should be interpreted with caution

Source

- Statistics Canada, Health Indicators, January 2005

To reduce the volume of numbers presented, the tables below use arrow symbols to represent whether or not there is a statistically significant difference between the ESC LHIN and Planning Area rates and the Ontario rates (based on the application of 95% confidence intervals). An upward facing arrow indicates that the rate is significantly higher, while a downward facing arrow indicates that the rate is significantly lower. No arrow indicates that the rate is not significantly different from the Ontario rate. The data presented are a three year average 2001. This is over five years ago. However, the nature of these mortalities are such that changes over time are usually slow because most of them are the results of lifestyle and environmental choices and associated morbidities are moderated by health care interventions.

Age Standardized Total Mortality (ICD-10 AOO-Y89)
rate per 100,00 population, three year average, 2001

	Both Sexes		Males		Females	
Planning Area	Rate	Sign. Diff.	Rate	Sign. Diff.	Rate	Sign. Diff.
Chatham-Kent	682.9	↑	882.2	↑	540.4	↑
Essex	640.2	↑	784.6	↑	536.0	↑
Lambton	662.1	↑	834.4	↑	530.5	↑
ESC LHIN	653.1	↑	814.3	↑	535.4	↑
Ontario	597.8		741.4		490.2	

Age standardized All Circulatory Disease Deaths (ICD-10 100-199)
rate per 100,00 population, three year average, 2001

	Both Sexes		Males		Females	
Planning Area	Rate	Sign. Diff.	Rate	Sign. Diff.	Rate	Sign. Diff.
Chatham-Kent	276.3	↑	360.7	↑	215.6	↑
Essex	242.9	↑	293.9	↑	203.9	↑
Lambton	242.0	↑	307.7	↑	191.6	↑
ESC LHIN	249.3	↑	309.8	↑	203.7	↑
Ontario	205.0		259.0		163.8	

Age Standardized Ischemic Heart Disease Deaths (ICD-10 120-125)
rate per 100,000 population, three year average, 2001

	Both Sexes		Males		Females	
Planning Area	Rate	Sign. Diff.	Rate	Sign. Diff.	Rate	Sign. Diff.
Chatham-Kent	190.9	↑	258.7	↑	142.8	↑
Essex	133.5	↑	178.8	↑	99.9	↑
Lambton	136.9	↑	189.3	↑	96.9	
ESC LHIN	145.6	↑	196.7	↑	108.1	↑
Ontario	118.3		160.3		86.3	

Age Standardized Cerebrovascular Disease Deaths (ICD-10 160-169)
rate per 100,000 population, three year average, 2001

	Both Sexes		Males		Females	
Planning Area	Rate	Sign. Diff.	Rate	Sign. Diff.	Rate	Sign. Diff.
Chatham-Kent	35.9		42.5		31.0	
Essex	59.8	↑	63.5	↑	56.5	↑
Lambton	50.1		57.4		44.5	
ESC LHIN	52.8	↑	57.8	↑	48.7	↑
Ontario	43.6		51.4		37.9	

Age Standardized All Respiratory Disease Deaths (ICD-10 J00-J99) rate per 100,000 population, three year average, 2001

	Both Sexes		Males		Females	
Planning Area	Rate	Sign. Diff.	Rate	Sign. Diff.	Rate	Sign. Diff.
Chatham-Kent	47.7		68.4		38.2	
Essex	38.0	↓	47.8	↓	33.3	
Lambton	45.2		57.2		37.8	
ESC LHIN	41.6		54.0		35.2	
Ontario	44.6		59.5		35.9	

Age Standardized Pneumonia and Influenza Deaths (ICD-10 J10-J18) rate per 100,000 population, three-year average, 2001

	Both Sexes		Males		Females	
Planning Area	Rate	Sign. Diff.	Rate	Sign. Diff.	Rate	Sign. Diff.
Chatham-Kent	11.7		11.6		11.8	
Essex	8.1	↓	11.7	↓	6.4	↓
Lambton	11.0		12.1		10.1	
ESC LHIN	9.5	↓	11.8	↓	8.4	↓
Ontario	12.9		16.0		11.2	

Age Standardized Bronchitis, Emphysema and Asthma Deaths (ICD-10 J40-J43) rate per 100,000 population, three year average, 2001

	Both Sexes		Males		Females	
Planning Area	Rate	Sign. Diff.	Rate	Sign. Diff.	Rate	Sign. Diff.
Chatham-Kent	1.7		3.1		--	
Essex	3.3		2.9		3.7	
Lambton	3.9		4.5		3.3	
ESC LHIN	3.1		3.3		3.0	
Ontario	3.1		3.7		2.7	

Age Standard Unintentional Injury Deaths (ICD-10 V01-X59, Y85-Y86)
rate per 100,000 population, three year average, 2001

	Both Sexes		Males		Females	
Planning Area	**Rate**	**Sign. Diff.**	**Rate**	**Sign. Diff.**	**Rate**	**Sign. Diff.**
Chatham-Kent	23.7		34.9		13.1	
Essex	20.0		27.1		13.5	
Lambton	25.5		33.4		18.3	
ESC LHIN	21.8		29.7		14.5	
Ontario	22.3		29.7		15.5	

Age Standardized AIDS Deaths (ICD-10 B20-B24)
rate per 100,000 population, three year average, 2001

	Both Sexes		Males		Females	
Planning Area	**Rate**	**Sign. Diff.**	**Rate**	**Sign. Diff.**	**Rate**	**Sign. Diff.**
Chatham-Kent	--		--		0.0	
Essex	0.9		1.7		--	
Lambton	--		--		0.0	
ESC LHIN	0.7		1.4		--	
Ontario	1.2		2.1		0.3	

"--"Rates suppressed due to small cell count

Leading Causes of Death, Males, ESC LHIN Planning Area & Ontario 2000-2001

Chatham-Kent		Essex		Lambton		Ontario	
Cause	% of Deaths	Cause	% of Deaths	Cause	% of Deaths	Cause	% of Deaths
IHD	30.5	IHD	22.6	IHD	23.7	IHD	21.8
Lung Cancer	7.1	Lung Cancer	9.7	Lung Cancer	9.4	Lung Cancer	8.1
CLRD	6.2	Stroke	6.2	Stroke	7.7	Stroke	6.2
Stroke	6.1	CLRD	3.4	CLRD	4.3	CLRD	4.4
Diabetes	5.0	Other HD	3.3	Diabetes	3.5	Other HD	3.9
Lymphatic Cancers	2.9	Colorectal Cancer	3.2	Lymphatic Cancers	3.3	Diabetes	3.5
Colorectal Cancer	2.6	Prostate cancer	3.2	Prostate Cancer	3.2	Prostate Cancer	3.3
Prostate Cancer	2.5	Lymphatic Cancers	2.8	Colorectal Cancer	3.1	Colorectal Cancer	3.2
Chronic Liver Disease	2.2	Diabetes	2.7	Other HD	2.8	Lymphatic Cancers	3.1
Motor Vehicle crashes	2.2	Chronic liver disease	2.1	Intentional Self-harm	2.3	Mental & Behaviour-al	2.0

CLRD - Chronic lower respiratory disease

Observations

- The mortality rates for all causes and all circulatory diseases are significantly higher across the Erie St. Clair LHIN for both males and females than the province
- The mortality rate for ischemic heart disease is significantly higher for males and females in Chatham-Kent and Essex, and for males in Lambton. The rate for females in Lambton is higher than the province, but is not considered to be statistically significant
- The mortality rates for pneumonia and influenza are significantly lower for males and females in Essex County, and lower but not statistically significant for Chatham-Kent and Lambton
- The mortality rates for bronchitis, emphysema and asthma, unintentional injury and AIDS are not significantly different than the province
- The mortality rates for unintentional injury deaths were not statistically different than the province
- Leading causes of death for males were ischemic heart disease (IHD), lung cancer, stroke and chronic lower respiratory disease (CLRD)
- Leading causes of death for females were IHD, stroke and lung cancer

Leading Causes of Death, Females, ESC LHIN Planning Area and Ontario 2000-2001

Chatham-Kent		Essex		Lambton		Ontario	
Cause	**% of Deaths**	**Cause**	**% of Deaths**	**Cause**	**% of Deaths**	**Cause**	**% of Deaths**
IHD	29.0	IHD	22.0	IHD	20.9	IHD	19.1
Stroke	9.2	Stroke	9.3	Stroke	11.3	Stroke	8.9
Lung Cancer	5.2	Lung Cancer	6.7	Lung Cancer	7.7	Lung Cancer	6.0
Diabetes	4.0	Atherosclerosis	5.0	CLRD	4.5	Other HD	4.9
Breast Cancer	4.0	CLRD	4.0	Other HD	4.0	Breast Cancer	4.7
CLRD	3.8	Other HD	3.9	Breast Cancer	3.8	CLRD	3.9
Other HD	3.0	Mental & Behavioural	3.8	Diabetes	3.5	Diabetes	3.6
Mental & Behavioural	2.6	Breast Cancer	3.6	Alzheimer's Disease	3.4	Mental & Behavioural	3.2
Alzheimer's Disease	2.5	Diabetes	3.2	Lymphatic Cancers	2.4	Alzheimer's Disease	3.1
Influenza & Pneumonia	2.3	Colorectal Cancer	3.0	Influenza & Pneumonia	2.4	Colorectal Cancer	2.8

CLRD - Chronic Lower Respiratory Disease

1.2 Potential Years of Life Lost (PYLL)

Definition

- Total years of life lost by members of a population who died prior to reaching the average life expectancy (age 75) in a given year, per 100,000 population. Years of life lost are calculated for each death as the difference between age at death and the standard age (75 years) and PYLL reflects the total years of life lost divided by the population (age 0-74) in that year

Significance/Uses

- PYLL is the number of years not lived by those who died prior to the average life expectancy. In 2001 the average life expectancy for Ontario females was 82.2 years, and 77.5 years for males
- Provides a measure of the major causes of premature mortality
- Index of the impact of premature death. Most improvements in life expectancy come from reductions in death rates at the older years. PYLL places more weight on deaths at an early age, which contribute more "unlived" years; however the actual number of deaths might be quite small
- PYLL varies by age, sex, SES etc. Standardized PYLL rates control for different age/sex structures of populations and thus control for two potential explanations for differences between rates
- Useful for establishing community health priorities

Limitations

- PYLL is somewhat overestimated, since not all the deceased would have reached the age limit, even if the cause of their death had been eliminated
- PYLL places more weight on deaths among the very young. Deaths among infants, from causes such as congenital malformations are rare but contribute more unlived years than other causes. Therefore leading causes of PYLL should be interpreted with caution, since they may be based on few deaths
- The shift to ICD-10 coding for causes of death in 2000 has led to some changes in the leading causes of PYLL. For 2000-2001, the codes for the leading causes are based on a subset of the "List of 113 Selected Causes of Death" developed by the National Center for Health Statistics in the US, which are comparable to the codes for the ICD-9 leading categories

Source

- Statistics Canada Health Indicators, January 2005

Methodology

Rates in this table are based on three consecutive years of death data which were summed and divided by three times the population estimate of the middle year of the three year period. ESC LHIN numbers were derived from Essex, Kent and Lambton District Health Council in the above referenced report.

Potential years of life lost (PYLL) – All causes of death (ICD-10 A00-Y89), age standardized rate per 100,000 population, three-year average, 2001

	Both Sexes		Males		Females	
Planning Area	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**
Chatham-Kent	5,953.2	↑	7,462.1	↑	4,430.5	↑
Essex	5,031.1	↑	6,048.4	↑	3,983.1	↑
Lambton	5,599.4	↑	6,963.5	↑	4,231.3	↑
ESC LHIN*	5,309.6	↑	6,481.4	↑	4,113.5	↑
Ontario	4,755.4		5,828.6		3,679.2	

Potential years of life lost (PYLL) - All Circulatory Disease deaths (ICD-10 I00-I99) age-standardized rate per 100,000 population, three-year average, 2001

	Both Sexes		Males		Females	
Planning Area	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**
Chatham-Kent	1,230	↑	1,769	↑	685	↑
Essex	860	↑	1,182		527	↑
Lambton	1,092	↑	1,550	↑	633	↑
ESC LHIN	972	↑	1,360	↑	577	↑
Ontario	823		1,153		493	

Potential years of life lost (PYLL) - Ischemic Heart Disease deaths (ICD-10 I20-I25) age-standardized rate per 100,000 population, three-year average, 2001

	All		Males		Females	
Planning Area	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**
Chatham-Kent	909	↑	1,334	↑	479	↑
Essex	528	↑	814	↑	233	
Lambton	737	↑	1,147	↑	325	↑
ESC LHIN	637	↑	973	↑	295	↑
Ontario	500		773		227	

Potential years of life lost (PYLL) - Cerebrovascular Disease deaths (ICD-10 I60-I69) age-standardized rate per 100,000 population, three-year average, 2001

	All		Males		Females	
Planning Area	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**
Chatham-Kent	168	↓	220		116	↓
Essex	218	↑	229		208	↑
Lambton	187		236		139	
ESC LHIN	203	↑	229		177	↑
Ontario	190		233		146	

Potential years of life lost (PYLL) - All Respiratory Disease deaths (ICD-10 J00-J99) age-standardized rate per 100,000 population, three-year average, 2001

	Both Sexes		Males		Females	
Planning Area	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**
Chatham-Kent	305	↑	277	↑	333	↑
Essex	172	↑	188	↑	155	↑
Lambton	181	↑	226	↑	136	
ESC LHIN	197	↑	211	↑	182	↑
Ontario	146		163		129	

Potential years of life lost (PYLL) - Pneumonia and Influenza deaths (ICD-10 J10-J18) age-standardized rate per 100,000 population, three-year average, 2001

Planning Area	Ave Rate	Sign Diff	Ave Rate	Sign Diff	Ave Rate	Sign Diff
Chatham-Kent	63	↑	51		76	↑
Essex	57	↑	76	↑	39	↑
Lambton	46	↑	62	↑	30	
ESC LHIN	56	↑	69	↑	43	↑
Ontario	37		43		31	

PYLL - Bronchitis, Emphysema and Asthma deaths (ICD-10 J40-J43, J45-J46) age-standardized rate per 100,000 population, three-year average, 2001

	Both Sexes		Males		Females	
Planning Area	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**
Chatham-Kent	22		43	↑	--	
Essex	17		14		19	
Lambton	17		22		12	↓
ESC LHIN	18		21	↑	14	↓
Ontario	18		17		19	

PYLL – All Unintentional Injury deaths (ICD-10 V01-X59, Y85-Y86) age-standardized rate per 100,000 population, three-year average, 2001

	Both Sexes		Males		Females	
Planning Area	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**
Chatham-Kent	657	↑	1,014	↑	297	↑
Essex	473		713		226	↓
Lambton	622	↑	876	↑	367	↑
ESC LHIN	536	↑	798	↑	268	↑
Ontario	471		690		250	

Potential years of life lost (PYLL) - AIDS deaths (ICD-10 B20-B24) age-standardized rate per 100,000 population, three-year average, 2001

"–"Rates suppressed due to small cell count

	Both Sexes		Males		Females	
Planning Area	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**
Chatham-Kent	10.4	↓	20.7	↓	--	
Essex	31.2	↓	57.5	↓	4.1	↓
Lambton	21.7	↓	43.4	↓	--	
ESC LHIN*	25.6	↓	48.2	↓	2.5	↓
Ontario	41.9		72.4		11.2	

Leading Causes of PYLL, Males, ESC LHIN Planning Area and Ontario, 2000-2001

Chatham-Kent		Essex		Lambton		Ontario	
Cause	% of PYLL	Cause	% of PYLL	Cause	% of PYLL	Cause	% of PYLL
IHD	19.6	IHD	14.4	IHD	15.7	IHD	13.5
Motor Vehicle Crashes	11.4	Lung Cancer	8.0	Intentional Self-harm	11.3	Lung Cancer	6.9
Intentional Self-harm	6.6	Intentional Self-harm	6.6	Lung Cancer	8.4	Intentional Self-harm	6.6
Lung Cancer	5.6	Congenital Malformation	4.5	Motor Vehicle Crashes	5.2	Motor Vehicle Crashes	5.8
Chronic Liver Disease	4.6	Motor Vehicle Crashes	3.9	Lymphatic Cancers	4.0	Perinatal Conditions	5.0
Diabetes	3.3	Non-transport Accidents	3.4	Chronic Liver Disease	3.1	Non-transport Accidents	4.9
Lymphatic Cancers	3.2	Lymphatic Cancers	3.0	Stroke	2.7	Lymphatic Cancers	3.4
Stroke	3.1	Chronic Liver Disease	2.8	Non-transport Accidents	2.7	Congenital Malformation	2.9
Colorectal Cancer	2.7	Perinatal Conditions	2.6	Perinatal Conditions	2.5	Infectious Diseases	2.9

Source: Vital Statistics PHPDB

Observations

- Males had higher PYLL rates than females. Chatham-Kent had the highest PYLL rates in ESC LHIN and the 2001 rates were 23% higher for males and 31% higher for females compared to Ontario
- Ischaemic heart disease (IHD) is the leading cause of PYLL among males. IHD was responsible for 14-20% of PYLL among males and 6-11% among females. For Essex males the next leading causes of PYLL were lung cancer, intentional self-harm and congenital malformation
- For Chatham-Kent males the next leading causes were motor vehicle crashes, intentional self-harm and lung cancer
- For Lambton the next leading causes were intentional self-harm, lung cancer and motor vehicle crashes

Leading Causes of PYLL, Females, ESC LHIN Planning Area and Ontario 2000-2001

Chatham-Kent		Essex		Lambton		Ontario	
Cause	**% of PYLL**	**Cause**	**% of PYLL**	**Cause**	**% of PYLL**	**Cause**	**% of PYLL**
IHD	11.1	Lung Cancer	10.0	Lung Cancer	12.5	Breast Cancer	9.1
Lung Cancer	8.7	IHD	7.1	Breast Cancer	9.4	Lung Cancer	8.4
Breast Cancer	7.4	Breast Cancer	6.7	IHD	7.8	IHD	6.3
Congenital Malformation	6.2	Congenital Malformation	6.3	Lymphatic Cancers	5.2	Perinatal Conditions	6.3
Motor Vehicle Crashes	5.8	Other Heart Disease	4.6	Stroke	5.1	Motor Vehicle Crashes	3.7
Lymphatic Cancers	3.5	Lymphatic Cancers	4.1	Intentional Self-harm	5.1	Lymphatic Cancers	3.6
CLRD	3.1	Perinatal Conditions	3.1	Motor Vehicle Crashes	4.9	Intentional Self-harm	3.5
Perinatal Conditions	2.9	Colorectal Cancer	3.0	Perinatal Conditions	2.9	Stroke	3.3
Non-transport Accidents	2.8	Intentional Self-harm	2.8	Congenital Malformation	2.5	Colorectal Cancer	2.9

CLRD - Chronic Lower Respiratory Disease

Observations (con't)

- For Ontario, the leading causes were IHD, lung cancer and intentional self-harm. IHD and diabetes accounted for a larger proportion of the total PYLL for Chatham-Kent compared to the other areas
- Among Essex females the leading causes of PYLL were lung cancer, IHD, breast cancer and congenital malformations
- For Chatham-Kent females, IHD, lung cancer, breast cancer and congenital malformations were the leading contributors of PYLL. Lung cancer, breast cancer, IHD and lymphatic cancers were the primary contributors in Lambton, while breast cancer, lung cancer, IHD and perinatal conditions were the leading causes for Ontario

1.3 Leading Causes of Hospitalization

Definition

- Leading causes of Hospitalization, ESC LHIN hospitals by program cluster categories 2004/05
- Hospitalization rates by ICD-10CA chapter for ESC LHIN and Ontario

Significance/Uses

- Reflects the PCC and ICD-10-CA chapter of the diagnosis, which is most responsible for the hospital stay
- Reflects a single episode within a hospital, a transfer to another facility will result in two separations
- Useful in planning health services and in identifying priority health problems
- Comparison over time and place
- Leading cause of morbidity vary by age group, sex and SES

Limitations

- Data includes residents and non-residents of ESC LHIN

Source

- Health System Intelligence Project, June 2006

Leading Causes of Hospitalization, ESC LHIN Hospitals by Program Cluster Categories 2004/2005

Chatham-Kent			Essex			Lambton			Erie St. Clair			Ontario
PCC	# Cases	% of total	PCC	# Cases	% of total	PCC	# Cases	% of total	PCC	# Cases	% of total	% of total
Cardiology	1,237	13.6	Obstetrics	5,094	15.3	Cardiology	1,541	14.7	Obstetrics	7,246	13.7	15.6
Obstetrics	1,149	12.7	Cardiology	3,507	10.6	Gastro/Hepatobiliary	1,031	9.8	Cardiology	6,285	11.9	10.6
Gastro/Hepatobiliary	1,050	11.6	Gastro/Hepatobiliary	2,817	8.5	Obstetrics	1,003	9.5	Gastro/Hepatobiliary	4,898	9.3	7.9
Pulmonary	860	9.5	General Surgery	2,670	8.0	General Surgery	879	8.4	Pulmonary	4,288	8.1	7.6
General Medicine	675	7.4	Psychiatry	2,633	7.9	Psychiatry	850	8.1	General Surgery	4,171	7.9	8.5
General Surgery	622	6.9	Pulmonary	2,579	7.8	Pulmonary	849	8.1	Psychiatry	4,049	7.7	5.8
Psychiatry	566	6.2	Orthopaedics	2,230	6.7	Orthopaedics	668	6.4	Orthopaedics	3,376	6.4	6.1
Orthopaedics	478	5.3	Urology	1,588	4.8	General Medicine	656	6.2	General Medicine	2,711	5.1	5.9
Neurology	396	4.4	Trauma	1,438	4.3	Urology	600	5.7	Urology	2,522	4.8	3.9
Gynaecology	385	4.2	General Medicine	1,380	4.2	Trauma	413	3.9	Trauma	2,151	4.1	4.7
Urology	334	3.7	Neurology	1,304	3.9	Neurology	410	3.9	Neurology	2,109	4.0	
Trauma	300	3.3	Oncology	1,217	3.7	Gynaecology	294	2.8	Gynaecology	1,806	3.4	
Oncology	245	2.7	Gynaecology	1,127	3.4	Oncology	270	2.6	Oncology	1,732	3.3	
Endocrinology	230	2.5	Endocrinology	613	1.8	Otolaryngology	243	2.3	Endocrinology	1,061	2.0	
Haematology	120	1.3	Otolaryngology	504	1.5	Endocrinology	218	2.1	Otolaryngology	830	1.6	
Nephrology	99	1.1	Cardio/Thoracic	392	1.2	Haematology	125	1.2	Haematology	593	1.1	
Otolaryngology	83	0.9	Nephrology	359	1.1	Cardio/Thoracic	110	1.0	Nephrology	549	1.0	
Neonatology	58	0.6	Vascular Surgery	359	1.1	Nephrology	91	0.9	Cardio/Thoracic	543	1.0	
Cardio/Thoracic	41	0.5	Haematology	348	1.0	Vascular Surgery	74	0.7	Vascular Surgery	463	0.9	
Rheumatology	35	0.4	Neonatology	252	0.8	Neonatology	64	0.6	Neonatology	374	0.7	
Vascular Surgery	30	0.3	Neurosurgery	241	0.7	Plastic Surgery	41	0.4	Plastic Surgery	281	0.5	
Plastic Surgery	20	0.2	Plastic Surgery	220	0.7	Rheumatology	36	0.3	Neurosurgery	243	0.5	
Dermatology	19	0.2	Not Generally	124	0.4	Dermatology	22	0.2	Rheumatology	156	0.3	
* Not Generally	17	0.2	Rheumatology	85	0.3	Rehabilitation	12	0.1	Not Generally	143	0.3	
Rehabilitation	12	0.1	Dermatology	68	0.2	Dental/Oral	6	0.1	Dermatology	109	0.2	
Ophthalmology	7	0.1	Ophthalmology	53	0.2	Neurosurgery	n/a		Ophthalmology	62	0.1	
Neurosurgery	n/a	0.0	Dental/Oral	16	0.0	Ophthalmology	n/a		Rehabilitation	28	0.1	
Dental/Oral	n/a	0.0	Ungroupable	5	0.0	Not Generally	n/a		Dental/Oral	22	0.0	
Ungroupable	n/a	0.0	Rehabilitation	n/a		Ungroupable	n/a		Ungroupable	5	0.0	
Total	9,067	100.0		33,223	100.0		10,506	100.0		52,806	100.0	

*Not Generally-illness does not require hospitalization

Source: Health System Intelligence Project, June 2006

Data included non-residents of Erie St. Clair LHIN

Erie St. Clair LHIN Hospitalization Rates by ICD-10CA Chapter, 2004/2005

sorted by ESC LHIN Age-Standardized Rates (descending)

	% of Total Hospitalizations		Crude Hospitalizations per 100K Popn		Age Standardized Hospitalization rate per 100K Popn	
ICD 10 Chapter	ESC LHIN	Ontario	ESC LHIN	Ontario	ESC LHIN	Ontario
Maternal conditions	11.0	14.0	1,036	1,137	1,290	1,359
Circulatory system diseases	15.4	14.3	1,450	1,155	1,187	988
Digestive system diseases	11.2	10.4	1,057	843	974	780
Respiratory system diseases	7.7	8.0	727	646	682	614
Mental & behavioural diseases	6.9	6.4	651	521	637	508
Neoplasms	7.8	7.5	738	603	632	531
Injury & poisoning, consequences of external causes	7.1	7.8	665	631	605	584
Genitourinary system diseases	7.0	5.7	657	462	595	425
Symptoms, signs not elsewhere classified	5.9	6.4	560	516	505	471
Factors influencing health status & contact with health services	5.0	5.2	475	425	483	421
Musculoskeletal system diseases	5.7	5.1	534	412	467	371
Endocrine, nutritional & metabolic diseases	2.3	2.4	221	195	198	178
Infectious and parasitic diseases	1.7	1.7	156	134	152	133
Diseases of nervous system	1.6	1.5	152	124	135	114
Diseases of blood and blood-forming organs	1.1	1.0	100	84	87	78
Perinatal conditions	0.6	0.7	58	54	82	76
Skin & subcutaneous tissue diseases	0.9	0.9	80	70	75	66
Congenital abnormalities	0.4	0.5	42	39	50	47
Diseases of ear and mastoid process	0.4	0.3	35	22	34	21
Diseases of eye and adnexa	0.3	0.2	27	20	25	19
Total			**9,423**	**8,094**	**8,897**	**7,783**

Source: Health System Intelligence Project, Spring 2006

Observations

- The top 10 Program Cluster Categories (PCC) for hospitals across the Erie St. Clair LHIN are very similar and represent approximately 80% of the total volume of cases. Obstetrics, cardiology and gastro-hepatobiliary are in the top three PCCs, for all areas, differing only in their order by total volume
- The Ontario comparative information is available for the top 10 only and shows that ESC LHIN has a higher percentage of cases than Ontario in cardiology, gastro hepatobiliary, pulmonary, psychiatry, orthopaedics and urology
- Review of the hospitalization rates by ICD-10 Chapter shows that circulatory diseases represent the highest proportion of hospital separations, followed by digestive system diseases and maternal conditions. This is generally in line with the leading Program Cluster Categories although the numbers vary slightly due to difference in grouping methodology
- Next in terms of volume were neoplasms, respiratory system diseases, injuries and genitourinary system diseases
- Overall, ESC LHIN has a higher hospitalization rate than the province, both in terms of crude

hospitalizations per 100,000 population as well as age standardized rates per 100,000. This is true for every category shown with the exception of maternal conditions

- Higher hospitalization rates may be due to a number of factors including lack of alternative community based services, practice patterns and shortages of primary care physicians

1.4 Life Expectancy and Disability-Free Life Expectancy

Definition

- Life Expectancy – number of years a person would be expected to live starting from birth on the basis of mortality trends for the period
- Disability-Free Life Expectancy (DFLE) – number of years a person would be expected to live without activity limitation, subjected to the mortality and disability experience of the specified population and time period

Significance/Uses

- Life expectancy is a traditional estimate of population health and captures the overall impact of death on a population
- DFLE combines life expectancy and quality of life measures and reflects the years of life lived in good health. Disability estimates are taken from 1996 census questions on activity limitation
- Used together, the two measures reflect the number of years of expected good health. When DFLE and Life Expectancy are relatively close, the average years of morbidity and disability are few, considered a compression of morbidity. A longer period would indicate a prolonged period of disability and higher relative need for LTC and other supportive services
- Indicator of the need for health care services

Limitations

- Reflects the average health of the population, but does not consider differences within subgroups of the population
- DFLE sets a threshold based on the presence of an activity limitation; however, the measure does not consider the relative severity of the disability. Although an individual may have some disability, the relative quality of life may not be seriously affected
- Questions on activity limitation may change over time; therefore changes in DFLE over time should be interpreted with caution. DFLE for 2001 is not yet available

Source

- Statistics Canada Health Indicators Report January 2005.

Life expectancy-abridged life table, at birth, three year average, 2001

	Both Sexes		Males		Females	
Planning Area	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**
Chatham-Kent	78.1	↓	75.3	↓	80.9	↓
Essex	79	↓	76.8	↓	81.1	↓
Lambton	78.6	↓	76	↓	81.2	↓
ESC LHIN*	78.7	↓	76.4	↓	81.1	↓
Ontario	79.7		77.4		82	

Disability-free life expectancy-abridged life table, at birth, 1996

	Both Sexes		Males		Females	
Planning Area	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**	**Ave Rate**	**Sign Diff**
Chatham-Kent	64.9	↓	63.5	↓	66.2	↓
Essex	66.6	↓	65	↓	68.2	↓
Lambton	67.7		66.1		69.2	
ESC LHIN*	66.5	↓	64.9	↓	68.1	↓
Ontario	68		66.6		69.4	

Observations

- In all cases (both sexes, each gender separately and for all planning areas and ESC LHIN overall), the life expectancy at birth was significantly lower than the Ontario rates in 2001
- Disability-Free Life Expectancy is significantly lower for both sexes and individual sexes for Chatham-Kent and Essex and ESC LHIN. Only Lambton is not significantly different from Ontario

1.5 Canadian Community Health Survey Information

Definition

- The Canadian Community Health Survey is a bi-annual process that samples the Canadian population's responses to a number of questions related to health. Each series contains a large number of common questions and a smaller set of questions on specific topics

Significance/Uses

- Provides a global measure of the individual's perception of their health and illness status, health-related lifestyles and use of health system resources in relation to that of their peers
- Predictive of future mortality, the development of chronic conditions and other functional limitations.
- Useful for identifying high-risk groups
- Useful for planning preventive and promotional interventions
- Comparison over time and between places

Common limitations

For all information in this section:

- The questions used may change slightly from one survey to another and therefore comparisons between surveys should be interpreted with caution
- Self-reports may be subjective and may not be supported by health care professionals or more rigorously collected information (e.g. birth and death data, hospital morbidity, etc.). It should be noted that Census data has the same important limitation. There is no public method of correlating Census responses with other datasets
- Self-reports may be subject to social desirability bias (e.g. drinking or sexual practices or smoking status)
- Most responses are based on persons aged 12 and over, unless otherwise noted

Sources

- CCHS 2005 (CCHS 3.1) – Statistics Canada CANSIM tables 4 series and Ontario Ministry of Finance Population Projections 2005-2031

Note to Readers: These tables are presented differently than previous HSM reports. Confidence intervals are not provided. However, a crude estimate of the numerical impact of various situations or conditions is presented by assigning the Ontario rate of each situation/condition to the populations in each planning area and the LHIN. This gives a rough estimate of the number of people who are better or worse off than would be expected based on the provincial average. This can be used as one tool in the prioritization process.

1.5.1 Self-Rated Health Status

Definition

- Proportion of individuals age 12+ who rate their health as very good or excellent, good, fair or poor

Significance/Uses

- Provides a global measure of the individual's perception of their health in relation to that of their peers
- Shown to be highly correlated with measures of health status, such as, prevalence of disease states and the

presence of functional limitations

- Predictive of future mortality, the development of chronic conditions and other functional limitations
- Self-ratings go beyond physical health and include factors such as incipient disease, disease severity, mental and social health, quality of life, positive health status, sense of control, health behaviours, etc.
- Indicator is useful for identifying high-risk groups
- Indicator is useful for planning preventive and promotional interventions
- Comparison over time and place

Limitations

- The questions used to measure self-rated health may change from one survey to another and therefore comparisons between surveys should be interpreted with caution
- Self-reports of general health status are subjective and may not be supported by health care professionals
- Self-reports may be subject to social desirability bias

Self Rated Health, 2005*

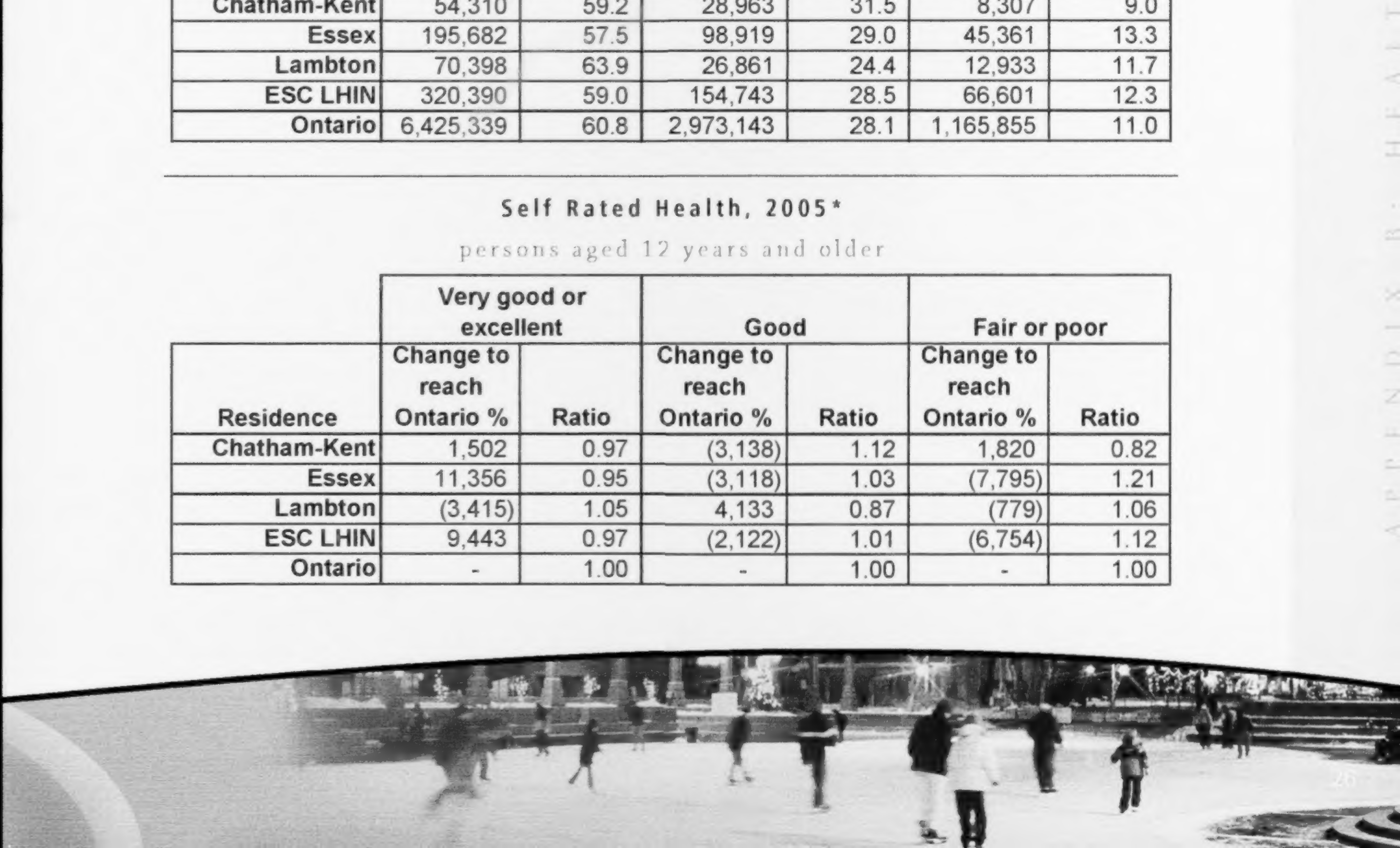
persons aged 12 years and older

	Very good or excellent		Good		Fair or poor	
Residence	Number	%	Number	%	Number	%
Chatham-Kent	54,310	59.2	28,963	31.5	8,307	9.0
Essex	195,682	57.5	98,919	29.0	45,361	13.3
Lambton	70,398	63.9	26,861	24.4	12,933	11.7
ESC LHIN	320,390	59.0	154,743	28.5	66,601	12.3
Ontario	6,425,339	60.8	2,973,143	28.1	1,165,855	11.0

Self Rated Health, 2005*

persons aged 12 years and older

	Very good or excellent		Good		Fair or poor	
Residence	Change to reach Ontario %	Ratio	Change to reach Ontario %	Ratio	Change to reach Ontario %	Ratio
Chatham-Kent	1,502	0.97	(3,138)	1.12	1,820	0.82
Essex	11,356	0.95	(3,118)	1.03	(7,795)	1.21
Lambton	(3,415)	1.05	4,133	0.87	(779)	1.06
ESC LHIN	9,443	0.97	(2,122)	1.01	(6,754)	1.12
Ontario	-	1.00	-	1.00	-	1.00



Observations

- About 60% of ESC LHIN and Ontario respondents reported that their health was excellent or very good Responses for ESC LHIN residents were generally comparable to Ontario for all categories; however, almost 7,800 more Essex residents than expected (based on Ontario percentage) reported that their health was fair or poor relative to Ontario
- An interesting anomaly is that despite markedly higher death rates, Chatham-Kent residents were as likely as Ontario residents to report having excellent or very good health

1.5.2 Self-Reported Mental Health

Definition

- Population aged 12 and over who rate their own mental health status as being excellent, very good, fair or poor
- Population aged 18 and over who rate their life stress as not at all, some or quite a lot

Significance/Uses

- Self-reported mental health provides a general indication of the population suffering from some form of mental disorder, mental or emotional problems, or distress, not necessarily reflected in self-reported (physical) health
- Life stress has a relationship to mental and physical health

Self Rated Mental Health, 2005*

persons aged 12 years and older

	Very good or excellent		Good		Fair or poor**	
Residence	**Number**	**%**	**Number**	**%**	**Number**	**%**
Chatham-Kent	67,897	74.0	17,312	18.9	4,035	4.4
Essex	250,083	73.4	64,435	18.9	14,877	4.4
Lambton	83,764	76.0	19,662	17.8	4,607	4.2
ESC LHIN	401,744	74.0	101,409	18.7	23,519	4.3
Ontario	7,698,333	72.8	2,105,367	19.9	522,178	4.9

Self Rated Mental Health, 2005*

persons aged 12 years and older

	Very good or excellent		Good		Fair or poor	
Residence	Change to reach Ontario %	Ratio	Change to reach Ontario %	Ratio	Change to reach Ontario %	Ratio
Chatham-Kent	(1,028)	1.02	976	0.95	501	0.90
Essex	(2,027)	1.01	3,404	0.95	1,949	0.90
Lambton	(3,510)	1.04	2,286	0.89	837	0.86
ESC LHIN	(6,565)	1.02	6,666	0.94	3,286	0.88
Ontario	-	1.00	-	1.00	-	1.00

Life Stress, 2005*

persons aged 18 and over

	Not at all		Some		Quite a lot	
Residence	Number	%	Number	%	Number	%
Chatham-Kent	11,135	13.5	53,613	64.9	17,581	21.3
Essex	36,341	11.9	198,896	65.0	70,181	22.9
Lambton	9,198	9.3	66,668	67.7	22,025	22.4
ESC LHIN	56,674	11.6	319,177	65.5	109,787	22.5
Ontario	1,018,302	10.6	6,300,769	65.9	2,214,285	23.1

Life Stress, 2005*

persons aged 18 and over

	Not at all		Some		Quite a lot	
Residence	Change to reach Ontario %	Ratio	Change to reach Ontario %	Ratio	Change to reach Ontario %	Ratio
Chatham-Kent	(2,345)	1.27	775	0.98	1,533	0.92
Essex	(3,769)	1.12	2,646	0.99	647	0.99
Lambton	1,281	0.88	(1,827)	1.03	762	0.97
ESC LHIN	(4,832)	1.09	1,594	0.99	2,942	0.97
Ontario	-	1.00	-	1.00	-	1.00

Observations

- ESC LHIN and its planning areas report better mental health than Ontarians overall
- Chatham Kent residents report 1.27 times higher rates of no life stress compared to Ontarians, followed by Essex residents (1.12 times). Lambton residents report fewer residents than Ontario rates for no life stress, but similar rates for "some" and "quite a lot" of life stress. The apparent inconsistency is related to the number of persons who did not answer the question

1.5.3 Self-Reported Sense of Belonging to Local Community

Definition

- Population aged 12 and over who rate their own sense of belonging to their local community as being excellent, very good, fair or poor

Significance/Uses

- A general indicator of isolation from the community that is related to good mental health

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Sense of belonging to Local Community, 2005*

persons aged 12 years and older

	Very strong or somewhat strong		Somewhat weak		Very weak	
Residence	**Number**	**%**	**Number**	**%**	**Number**	**%**
Chatham-Kent	63,453	69.1	18,957	20.6	6,309	6.9
Essex	221,341	65.0	75,347	22.1	30,809	9.0
Lambton	82,798	75.1	19,734	17.9	4,925	4.5
ESC LHIN	367,592	67.7	114,038	21.0	42,043	7.7
Ontario	6,700,754	63.4	2,541,510	24.0	986,277	9.3

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Sense of Belonging to Local Community, 2005*

persons aged 12 years and older

	Very strong or somewhat strong		Somewhat weak		Very weak	
Residence	Change to reach Ontario %	Ratio	Change to reach Ontario %	Ratio	Change to reach Ontario %	Ratio
Chatham-Kent	(5,249)	1.09	3,119	0.86	2,258	0.74
Essex	(5,429)	1.03	6,546	0.92	971	0.97
Lambton	(12,944)	1.18	6,761	0.75	5,357	0.48
ESC LHIN	(23,621)	1.07	16,426	0.88	8,586	0.83
Ontario	-	1.00	-	1.00	-	1.00

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Observations

- Lambton residents reported the highest sense of belonging, followed by Chatham-Kent residents. Essex was similar to Ontario rates

1.5.4 Body Mass Index (youth and adult)

Definition

- Youth: for persons between 12 and 17 years of age who are not pregnant, based on internationally developed age and sex-specific percentile tables of height and weight
- Adults: the ratio of body weight (kg) to height (m) squared, among individuals age 18+, excluding pregnant women and individuals <3 feet (0.914 m) tall or >7 feet (2.108 m) tall

- ***International Standard Categories***
- BMI <18.5 - Underweight; 18.5-24.9 - Normal Weight; 25.0-29.9 - Overweight
- >30.0 - Obese - 3 further sub-categories:
  - Class I - 30.0-34.9 - high risk, Class II - 35.0-39.9 - very high risk, Class III - >40 - extremely high risk.

Significance/Uses

- BMI is the recommended measure of weight status
- Varies between males and females
- Rates of illness and premature mortality are higher among underweight, overweight and obese people
- Excess weight is associated with many health problems, including heart disease, type 2 diabetes, high blood

pressure, stroke and cancer and is a predictor of health problems prior to age 60

- Useful for planning preventive and promotional initiatives and health objectives
- Monitoring BMI provides information on the effectiveness of healthy lifestyle programs

Limitations

- BMI does not consider the distribution of body muscle and therefore may overestimate the number of overweight individuals
- BMI is typically underestimated due to respondent tendencies to overestimate height and underestimate weight; therefore reports are subject to social desirability bias

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Self-reported Youth Body Mass Index, 2005*

persons aged 12 to 17 excluding pregnant females

	Neither overweight nor obese		Overweight or obese**	
Residence	**Number**	**%**	**Number**	**%**
Chatham-Kent	6,932	75.1	1,490	16.2
Essex	25,944	75.1	6,334	18.3
Lambton	9,097	78.6	1,900	16.4
ESC LHIN	41,973	75.8	9,724	17.6
Ontario	747,906	74.8	181,238	18.1

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

**Use Lambton, Chatham-Kent, Essex with caution

Self-reported Youth Body Mass Index, 2005*

persons aged 12 to 17 excluding pregnant females

	Neither overweight nor obese		Overweight or obese**	
Residence	**Change to reach Ontario %**	**Ratio**	**Change to reach Ontario %**	**Ratio**
Chatham-Kent	(30)	1.00	183	0.90
Essex	(97)	1.00	(70)	1.01
Lambton	(441)	1.05	198	0.91
ESC LHIN	(568)	1.01	310	0.97
Ontario	-	1.00	-	1.00

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005 (CANSIM table 105-0408).

**Use Lambton, Chatham-Kent, Essex with caution

Observations

- Body Mass Indices among youth throughout ESC LHIN are very similar to Ontario rates

Self-reported Adult Body Mass Index, 2005*

persons aged 18 and older

	Underweight, BMI under 18.50**		Normal weight, BMI 18.50 to 24.99		Overweight, BMI 25.00 to 29.99		Obese, BMI 30.00 or higher	
Residence	Number	%	Number	%	Number	%	Number	%
Chatham-Kent	1,483	1.8	34,376	42.2	26,687	32.7	16,573	20.3
Essex	6,496	2.1	117,435	38.7	111,544	36.8	60,402	19.9
Lambton	-	-	44,241	45.4	32,804	33.7	18,181	18.7
ESC LHIN	7,979	1.8	196,052	40.7	171,035	35.5	95,156	19.7
Ontario	256,035	2.7	4,387,425	46.3	3,166,975	33.4	1,427,890	15.1

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Self-reported Adult Body Mass Index, 2005

persons aged 18 and older

	Underweight, BMI under 18.50**		Normal weight, BMI 18.50 to 24.99		Overweight, BMI 25.00 to 29.99		Obese, BMI 30.00 or higher	
Residence	Change to reach Ontario %	Ratio	Change to reach Ontario %	Ratio	Change to reach Ontario %	Ratio	Change to reach Ontario %	Ratio
Chatham-Kent	719	0.67	3,357	0.91	550	0.98	(4,293)	1.34
Essex	1,701	0.78	23,023	0.84	(10,157)	1.10	(14,690)	1.32
Lambton	2,632	-	856	0.98	(251)	1.01	(3,504)	1.24
ESC LHIN	5,051	0.67	27,236	0.88	(9,859)	1.06	(22,487)	1.30
Ontario	-	1.00	-	1.00	-	1.00	-	1.00

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Observations

- Obesity rates across ESC LHIN are much higher than Ontario rates. On average the ESC LHIN obesity rate is 1.3 times the Ontario rate

1.5.5 Tobacco Use

Definition

- A number of tables are included in this section. The first two are related to user-chosen tobacco use and the last two are related to smoke in the person's environment
- The first reports current smoking status by frequency of use for persons aged 12 and over
- The second table reports age group of smoking initiation regardless of current smoking status
- The third and fourth report exposure to second-hand smoke at home, in vehicles and public

Significance/Uses

- Smoking is highly addictive
- Cigarette smoking is linked to an increased risk of poor general health and frequent hospitalization Smokers are at increased risk of morbidity and mortality associated with cardiovascular disease, cancer and respiratory problems
- Smoking during pregnancy is associated with an increased risk of low birth weight babies
- Monitoring smoking prevalence provides important information for public health smoking prevention and cessation initiatives
- Useful in monitoring the impact of recent no smoking by laws on smoking status
- Comparison over time and place and to Mandatory Health Programs and Services Guidelines

Limitations

- This measure does not consider the intensity of tobacco use, which is a further index of the risk of morbidity and mortality
- Self-reports are subject to social desirability bias, which may underestimate the true rates of smoking
- The survey data includes cigarette smoking only

Smoking Initiation, 2005

persons aged 12 years and older both smokers and former smokers

	5 to 14 years		15 to 19 years		20 years and over	
Residence	**Number**	**%**	**Number**	**%**	**Number**	**%**
Chatham-Kent	21,175	38.8	26,190	48.0	5,730	10.5
Essex	70,031	35.1	94,576	47.4	27,293	13.7
Lambton	28,845	41.3	32,954	47.2	6,924	9.9
ESC LHIN	120,051	37.1	153,720	47.5	39,947	12.3
Ontario	2,000,554	32.7	3,051,780	49.9	885,126	14.5

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Smoking Initiation, 2005

persons aged 12 years and older both smokers and former smokers

	5 to 14 years		15 to 19 years		20 years and over	
Residence	**Change to reach Ontario %**	**Ratio**	**Change to reach Ontario %**	**Ratio**	**Change to reach Ontario %**	**Ratio**
Chatham-Kent	(3,331)	1.19	1,030	0.96	2,165	0.72
Essex	(4,831)	1.07	4,885	0.95	1,554	0.94
Lambton	(5,994)	1.26	1,905	0.95	3,186	0.68
ESC LHIN	(14,156)	1.13	7,819	0.95	6,905	0.85
Ontario	-	1.00	-	1.00	-	1.00

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Type of Smoker, 2005*

persons aged 12 years and older

	Current daily or occasional smoker		Former smoker		Never smoked	
Residence	**Number**	**%**	**Number**	**%**	**Number**	**%**
Chatham-Kent	22,372	24.4	30,973	33.7	37,256	40.6
Essex	80,091	23.5	114,228	33.5	141,062	41.4
Lambton	27,079	24.6	42,456	38.5	40,215	36.5
ESC LHIN	129,542	23.9	187,657	34.6	218,533	40.3
Ontario	2,186,990	20.7	3,824,830	36.2	4,449,088	42.1

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Type of Smoker, 2005*

persons aged 12 years and older

	Current daily or occasional smoker		Former smoker		Never smoked	
Residence	**Change to reach Ontario %**	**Ratio**	**Change to reach Ontario %**	**Ratio**	**Change to reach Ontario %**	**Ratio**
Chatham-Kent	(3,375)	1.18	2,250	0.93	1,390	0.96
Essex	(9,622)	1.14	9,016	0.93	2,297	0.98
Lambton	(4,280)	1.19	(2,583)	1.06	6,166	0.87
ESC LHIN	(17,277)	1.15	8,683	0.96	9,853	0.96
Ontario	-	1.00	-	1.00	-	1.00

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Exposure to Second-hand smoke at Home, 2005*

persons aged 12 years and older

	Exposed to second-hand smoke at home		No exposure to second-hand smoke at home	
Residence	**Number**	**%**	**Number**	**%**
Chatham-Kent	6,948	10.2	61,281	89.8
Essex	21,893	8.5	234,005	91.4
Lambton	8,546	10.3	74,126	89.7
ESC LHIN	37,387	9.2	369,412	90.8
Ontario	606,367	7.3	7,661,652	92.5

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005 (CANSIM table 105-0456)

Exposure to Second-hand smoke at Home*

persons aged 12 years and older

	Exposed to second-hand smoke at home		No exposure to second-hand smoke at home	
Residence	**Change to reach Ontario %**	**Ratio**	**Change to reach Ontario %**	**Ratio**
Chatham-Kent	(1,952)	1.40	1,842	0.97
Essex	(3,143)	1.16	2,902	0.99
Lambton	(2,493)	1.41	2,358	0.97
ESC LHIN	(7,588)	1.26	7,102	0.98
Ontario	-	1.00	-	1.00

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Exposure to Second-hand Smoke in Public Places, 2005*

persons aged 12 years and older

	In vehicles**		In public places**	
Residence	**Number**	**%**	**Number**	**%**
Chatham-Kent	7,284	10.7	4,518	6.6
Essex	23,301	9.1	50,375	19.7
Lambton	6,879	8.3	5,337	6.5
ESC LHIN	37,464	9.2	60,230	14.8
Ontario	648,408	7.8	1,077,586	13.0

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

**use S-L, Chatham-Kent with caution)

Exposure to Second-hand Smoke in Public Places, 2005*

persons aged 12 years and older

	In vehicles**		In public places**	
Residence	**Change to reach Ontario %**	**Ratio**	**Change to reach Ontario %**	**Ratio**
Chatham-Kent	(1,942)	1.37	4,360	0.51
Essex	(3,251)	1.17	(17,055)	1.52
Lambton	(406)	1.06	5,420	0.50
ESC LHIN	(5,599)	1.18	(7,274)	1.14
Ontario	-	1.00	-	1.00

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005 (CANSIM table 105-0457)
**use S-L, C-K with caution

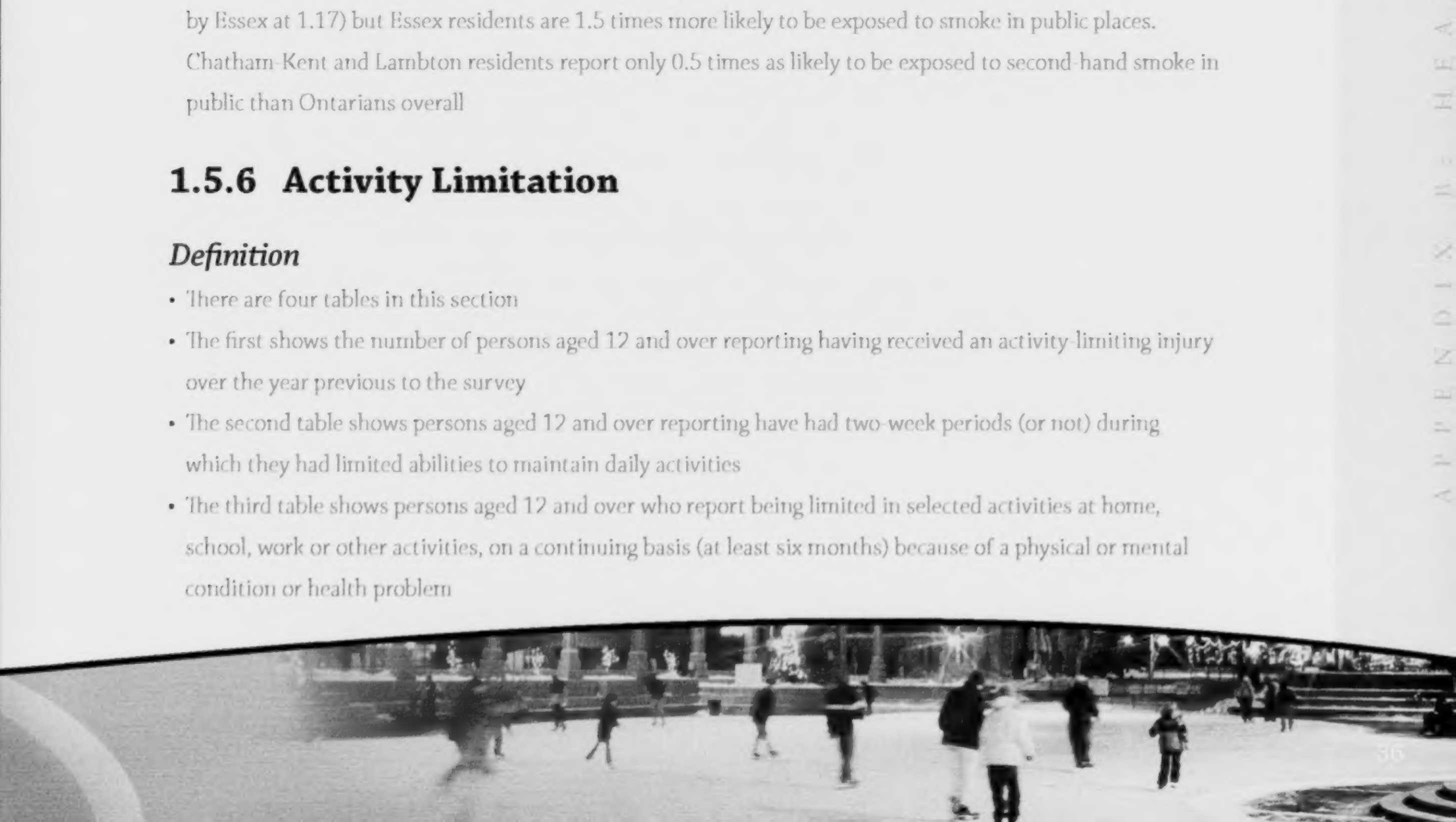
Observations

- Chatham-Kent and Lambton residents who started smoking started in the five to 14-year-old age group much more frequently than Essex residents and Ontarians
- There are 1.15 times as many current or occasional smokers in ESC LHIN than in Ontario as a whole. Lambton and Chatham-Kent residents had the highest rates of smokers in the LHIN
- 1.4 times as many residents are exposed to second-hand smoke at home compared to Ontarians overall
- 1.37 times as many Chatham-Kent residents are exposed to second-hand smoke in vehicles (followed by Essex at 1.17) but Essex residents are 1.5 times more likely to be exposed to smoke in public places. Chatham-Kent and Lambton residents report only 0.5 times as likely to be exposed to second-hand smoke in public than Ontarians overall

1.5.6 Activity Limitation

Definition

- There are four tables in this section
- The first shows the number of persons aged 12 and over reporting having received an activity-limiting injury over the year previous to the survey
- The second table shows persons aged 12 and over reporting have had two-week periods (or not) during which they had limited abilities to maintain daily activities
- The third table shows persons aged 12 and over who report being limited in selected activities at home, school, work or other activities, on a continuing basis (at least six months) because of a physical or mental condition or health problem



Significance/Uses

- Activity limitation can stem from conditions related to mortality or morbidity
- Measures the impact of health conditions and problems on selected aspects of life
- Activity limitations vary with age, gender and SES
- Activity limitations affect health and the use of health services including community support services
- Useful for planning for health needs and services

Injuries within the past 12 months causing limitation of normal activities, 2005*

persons aged 12 years and older

	Injuries		No injuries	
Residence	Number	%	Number	%
Chatham-Kent	11,736	12.8	77,453	84.4
Essex	46,535	13.7	283,550	83.3
Lambton	14,784	13.4	93,929	85.2
ESC LHIN	73,055	13.5	454,932	83.8
Ontario	1,427,040	13.5	8,874,539	84.0

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Injuries within the past 12 months causing limitation of normal activities, 2005*

persons aged 12 years and older

	Injuries		No injuries	
Residence	Change to reach Ontario %	Ratio	Change to reach Ontario %	Ratio
Chatham-Kent	660	0.95	(367)	1.00
Essex	(553)	1.01	2,406	0.99
Lambton	93	0.99	(1,414)	1.01
ESC LHIN	199	1.00	626	1.00
Ontario	-	1.00	-	1.00

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Two-week Disability Days, 2005*

persons aged 12 years and older

	No two-week disability days		1 or more two-week disability days	
Residence	**Number**	**%**	**Number**	**%**
Chatham-Kent	77,316	84.2	13,989	15.2
Essex	277,370	81.4	62,201	18.3
Lambton	88,787	80.6	21,031	19.1
ESC LHIN	443,473	81.7	97,221	17.9
Ontario	8,719,662	82.5	1,808,025	17.1

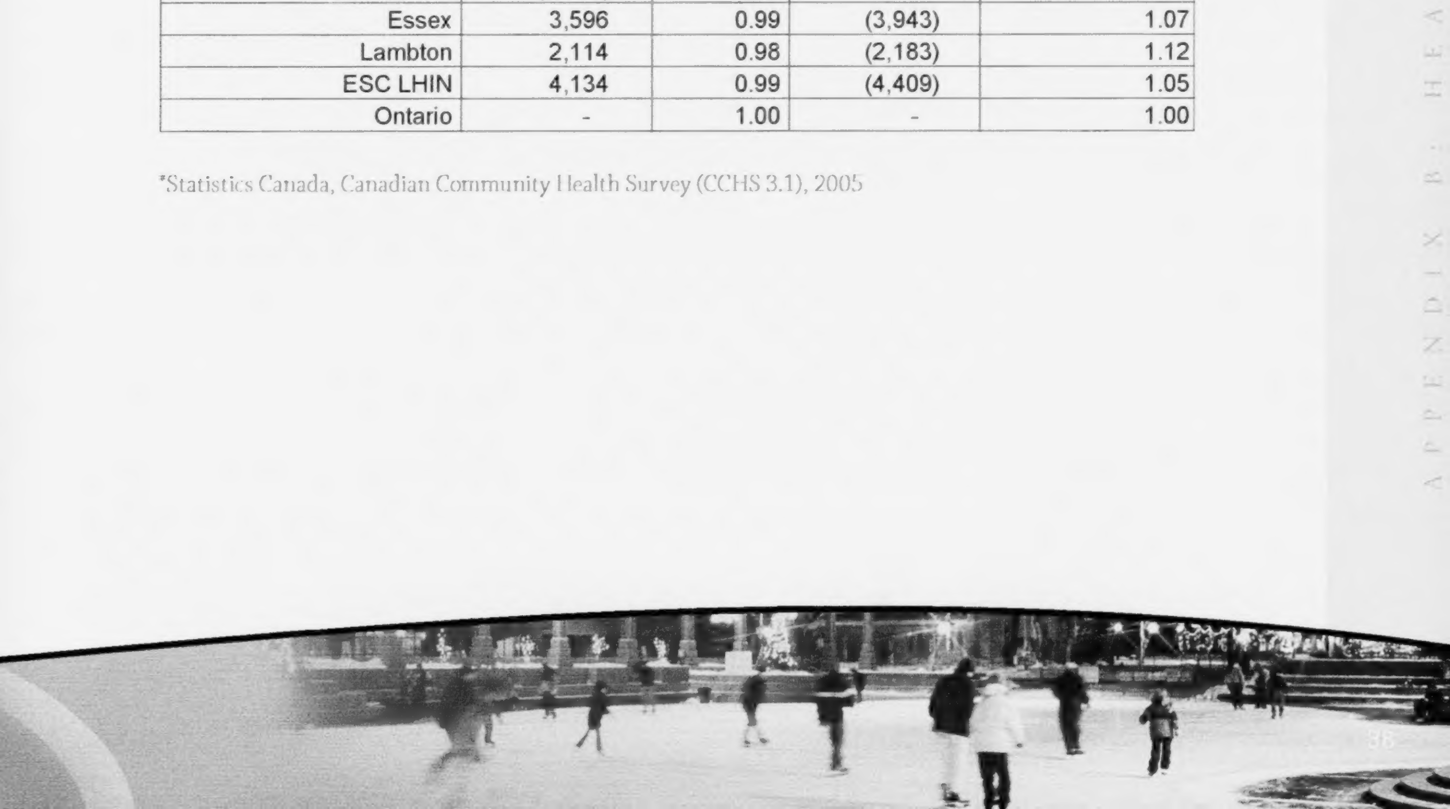
*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Two-week Disability Days, 2005*

persons aged 12 years and older

	No two-week disability days		1 or more two-week disability days	
Residence	**Change to reach Ontario %**	**Ratio**	**Change to reach Ontario %**	**Ratio**
Chatham-Kent	(1,575)	1.02	1,716	0.89
Essex	3,596	0.99	(3,943)	1.07
Lambton	2,114	0.98	(2,183)	1.12
ESC LHIN	4,134	0.99	(4,409)	1.05
Ontario	-	1.00	-	1.00

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005



Participation and Activity Limitation, 2005*

persons aged 12 years and older

	Participation and activity limitation		No participation and activity limitation	
Residence	**Number**	**%**	**Number**	**%**
Chatham-Kent	28,120	30.6	63,434	69.1
Essex	104,383	30.6	236,207	69.4
Lambton	35,945	32.6	74,054	67.2
ESC LHIN	168,448	31.0	373,695	68.9
Ontario	3,103,714	29.4	7,432,643	70.3

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Participation and Activity Limitation, 2005*

persons aged 12 years and older

	Participation and activity limitation		No participation and activity limitation	
Residence	**Change to reach Ontario %**	**Ratio**	**Change to reach Ontario %**	**Ratio**
Chatham-Kent	(1,160)	1.04	1,128	0.98
Essex	(4,375)	1.04	3,288	0.99
Lambton	(3,589)	1.11	3,430	0.96
ESC LHIN	(9,125)	1.05	7,846	0.98
Ontario	-	1.00	-	1.00

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Observations

- There were no differences in the number of persons reporting activity-limiting injuries in the year prior to the survey
- Compared to Ontarians, fewer Chatham-Kent residents reported two-week disability day periods while 1.12 times as many Lambton residents reported disability periods, while Essex was slightly higher than Ontario at 1.07 times higher
- Lambton had 1.11 times as many persons reporting six-month limitation periods compared to Ontario overall

1.5.7 Self-Reported Chronic Conditions

Definition

- Proportion of the population age 12+ reporting selected chronic health problems, which had been diagnosed by a health professional and had lasted or were expected to last six months or more

Significance/Uses

- Provides an estimate of the prevalence of specific conditions that influence health status and health care utilization
- Provides an estimate of the impact of various conditions within the community
- Useful for identifying priority health problems and planning preventive and promotional interventions
- Comparison over time and place and to Mandatory Health Programs and Services Guidelines

Limitations

- Prevalence may be underestimated since the conditions must be diagnosed by a health professional, there may be many individuals living with undiagnosed chronic conditions
- Self reports may be subject to social desirability bias
- The conditions shown are only a select (as included in the Statistics Canada Health Indicators Report) subset of the chronic conditions included in CCHS

Arthritis or Rheumatism, 2005*

persons aged 12 years and older

	With arthritis or rheumatism		Without arthritis or rheumatism	
Residence	**Number**	**%**	**Number**	**%**
Chatham-Kent	17,438	19.0	74,269	80.9
Lambton	26,790	24.3	83,401	75.7
Essex	70,437	20.7	269,478	79.1
ESC LHIN	114,665	21.1	427,148	78.7
Ontario	1,810,890	17.1	8,739,998	82.7

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Arthritis or Rheumatism, 2005*

persons aged 12 years and older

	With arthritis or rheumatism		Without arthritis or rheumatism	
Residence	**Change to reach Ontario %**	**Ratio**	**Change to reach Ontario %**	**Ratio**
Chatham-Kent	(1,708)	1.11	1,649	0.98
Essex	(12,086)	1.21	12,143	0.96
Lambton	(7,912)	1.42	7,712	0.92
ESC LHIN	(21,706)	1.23	21,503	0.95
Ontario	-	1.00	-	1.00

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Diabetes, 2005*

persons aged 12 years and older

	With diabetes		Without diabetes	
Residence	**Number**	**%**	**Number**	**%**
Chatham-Kent	5,716	6.2	85,922	93.6
Essex	17,837	5.2	322,247	94.6
Lambton	6,185	5.6	103,814	94.2
ESC LHIN	29,738	5.5	511,983	94.4
Ontario	510,253	4.8	10,049,056	95.1

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Diabetes, 2005*

persons aged 12 years and older

	With diabetes		Without diabetes	
Residence	**Change to reach Ontario %**	**Ratio**	**Change to reach Ontario %**	**Ratio**
Chatham-Kent	(1,284)	1.29	1,366	0.98
Essex	(1,396)	1.08	1,555	0.99
Lambton	(866)	1.17	945	0.99
ESC LHIN	(3,545)	1.15	3,866	0.99
Ontario	-	1.00	-	1.00

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Asthma, 2005*

persons aged 12 years and older

	With asthma		Without asthma	
Residence	**Number**	**%**	**Number**	**%**
Chatham-Kent	9,467	10.3	82,171	89.5
Essex	25,931	7.6	314,209	92.3
Lambton	10,809	9.8	99,325	90.1
ESC LHIN	46,207	8.5	495,705	91.4
Ontario	843,339	8.0	9,720,839	92.0

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Asthma, 2005*

persons aged 12 years and older

	With asthma		Without asthma	
Residence	**Change to reach Ontario %**	**Ratio**	**Change to reach Ontario %**	**Ratio**
Chatham-Kent	(2,142)	1.29	2,266	0.97
Essex	1,243	0.95	(983)	1.00
Lambton	(2,017)	1.23	2,013	0.98
ESC LHIN	(2,916)	1.06	3,296	0.99
Ontario	-	1.00	-	1.00

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

High Blood Pressure, 2005*

persons aged 12 years and older

	With high blood pressure		Without high blood pressure	
Residence	**Number**	**%**	**Number**	**%**
Chatham-Kent	16,410	17.9	74,956	81.6
Essex	57,028	16.7	283,265	83.2
Lambton	19,144	17.4	90,622	82.2
ESC LHIN	92,582	17.1	448,843	82.7
Ontario	1,611,807	15.2	8,929,411	84.5

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

High Blood Pressure, 2005*

persons aged 12 years and older

	With high blood pressure		Without high blood pressure	
Residence	**Change to reach Ontario %**	**Ratio**	**Change to reach Ontario %**	**Ratio**
Chatham-Kent	(2,409)	1.18	2,607	0.97
Essex	(5,092)	1.10	4,459	0.98
Lambton	(2,341)	1.14	2,465	0.97
ESC LHIN	(9,843)	1.13	9,532	0.98
Ontario	-	1.00	-	1.00

*Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005

Observations

- All planning areas reported higher rates of arthritis or rheumatism, with the highest prevalence in Lambton (1.42 times Ontario)
- All planning areas reported higher rates of diabetes, with the highest prevalence in Chatham-Kent (1.29) followed by Lambton (1.17)
- Chatham-Kent (1.29) and Lambton (1.23) reported higher rates of asthma compared to Ontario. Essex was slightly lower (0.95)
- All planning areas reported higher rates of high blood pressure, with the highest prevalence in Chatham-Kent (1.18), Lambton (1.14) and Essex at 1.1 times Ontario rates

1.5.8 Use of Health Professionals

Definitions

- Based on self-reported information from the Canadian Community Health Survey 2005 related to contact with selected health professionals over the 12 months prior to the CCHS

Significance/Uses

- Provides a crude estimate of relative access and need for care

Limitations

- Use is driven by many unrelated factors such as access, perceived need for care, belief in potential cost/benefit to the interaction, and provider-driven demand
- Twelve month recollections suffer from memory limitations
- Frequency of contact is not provided

Source

- Canadian Community Health Survey 2005, version ((CCHS 3.1), 2005 (CANSIM Table 105-0460)

Contact with Health Professionals in the past twelve months, 2005

	with Alternate Health Provider		with Medical Professional		with Professional regarding Mental Health		with Dental Professional	
Residence	Number	%	Number	%	Number	%	Number	%
Chatham-Kent	9,542	10.4	71,487	77.9	6,828	7.4	56,910	62.0
Essex	37,888	11.1	283,908	83.4	24,472	7.2	250,158	73.4
Lambton	13,650	12.4	90,904	82.5	8,935	8.1	80,232	72.8
ESC LHIN	61,080	11.3	446,299	82.3	40,235	7.4	387,300	71.4
Ontario	1,271,178	12.0	8,611,627	81.5	744,855	7.0	7,365,066	69.7

	with Alternate Health Provider		with Medical Professional		with Professional regarding Mental Health		with Dental Professional	
Residence	Change to reach Ontario %	Ratio	Change to reach Ontario %	Ratio	Change to reach Ontario %	Ratio	Change to reach Ontario %	Ratio
Chatham-Kent	1,500	0.86	3,315	0.96	(358)	1.06	7,065	0.89
Essex	3,072	0.92	(6,423)	1.02	(471)	1.02	(12,840)	1.05
Lambton	(398)	1.03	(1,129)	1.01	(1,170)	1.15	(3,453)	1.04
ESC LHIN	4,174	0.94	(4,237)	1.01	(1,999)	1.05	(9,228)	1.02
Ontario	-	1.00	-	1.00	-	1.00	-	1.00

Observations

- Contacts with alternate health providers is 0.86 to 0.92 times lower in Chatham-Kent and Essex compared to Ontario overall
- All Planning Area residents report Medical Professional utilization that is very similar to Ontario rates
- Contacts regarding mental health issues is 1.15 times higher in Lambton than in Ontario overall
- Contact with Dental Professionals is 0.89 times lower in Chatham-Kent than Ontario overall while Essex and Lambton contacts are 1.04-1.05 higher

1.6 Cancer Incidence and Mortality

Definition

- Age Standardized Incidence (new cases) Rates (ASIR) of selected cancers by sex/100,000 population for three years ending 2002
- Age Standardized Mortality Rates (ASMR) due to selected cancers by sex/100,000 population for three years ending 2001

Significance/Uses

- Useful for health promotion and health services planning
- May allow the identification of potential risk factors and hypothesis generation for research
- Comparison over time and place and to Mandatory Health Programs and Services Guidelines
- Changes in incidence and mortality may reflect trends in risk factors or changes in diagnostic and treatment practices
- Cancer Care Ontario estimates that tobacco is responsible for ~33% of all cancers, 33% are attributable to the combination of food, obesity and physical inactivity, ~8% may be caused by environmental or occupational exposures, 8% by genetic factors and 5% by infectious agents. For more information see: www.cancercare.on.ca/reports_228.htm

Limitations

- Incidence based on three year average, 2002
- Mortality and PYLL based on three year average, 2001
- Cancer incidence rates are age-standardized using the direct method and the 1991 Canadian census population structure
- Rates are based on three consecutive years of cancer incidence data which were summed and divided by three times the population estimate of the middle year of the three year period
- Ontario age-standardized rates are provisional

Source

- Statistics Canada, Health Indicators December 2005

Age Standardized Cancer Incidence - All Invasive Primary Cancer sites (including in situ bladder), rate per 100,000 population, three year average, 2002

Planning Area	Both Sexes		Males		Females	
	Rate	Sign. Diff.	Rate	Sign. Diff.	Rate	Sign. Diff.
Chatham-Kent	417.6	↑	498.1	↑	360.3	
Essex	405.5		488.0	↑	346.9	
Lambton	418.2	↑	492.8	↑	365.9	
ESC LHIN	410.7	↑	490.9	↑	354.1	
Ontario	393.0		452.2		350.5	

Age Standardized Cancer Incidence - Bronchus and Lung Cancer (ICD-10 C34.0 to C34.9;excluding M-9590 to M-9989), rate per 100,000 population, three year average, 2002

Planning Area	Both Sexes		Males		Females	
	Rate	Sign. Diff.	Rate	Sign. Diff.	Rate	Sign. Diff.
Chatham-Kent	56.3		72.0		42.4	
Essex	59.4	↑	73.7	↑	49.0	↑
Lambton	64.9	↑	76.8	↑	56.3	↑
ESC LHIN	60.1	↑	74.1	↑	49.5	↑
Ontario	50.4		62.9		40.7	

Age Standardized Cancer Incidence - Rectum and Rectosigmoid Junction Cancer (ICD-10 C18.0 to C18.9, C19.9, C20.0; excluding M-9590 to M-9989), rate per 100,000 population, three year average, 2002

Planning Area	Both Sexes		Males		Females	
	Rate	Sign. Diff.	Rate	Sign. Diff.	Rate	Sign. Diff.
Chatham-Kent	52.7		63.8		44.2	
Essex	50		63.1		38.8	
Lambton	54.9		68.5		44.8	
ESC LHIN	51.8		64.7		41.3	
Ontario	49.2		59.2		40.9	

Age Standardized Cancer Incidence - Female Breast Cancer (ICD-10 C50.0 to C50.9; excluding M-9590 to M-9989), rate per 100,000 population, three year average, 2002

Planning Area	Females	
	Rate	Sign. Diff.
Chatham-Kent	103.9	
Essex	98.6	
Lambton	101.2	
ESC LHIN	100.2	
Ontario	99.1	

Age Standardized Cancer Incidence - Prostate Cancer ICD-10 C61.9; excluding M-9590 to M-9989), rate per 100,000 population, three year average, 2002

Planning Area	Males	
	Rate	Sign. Diff.
Chatham-Kent	148.7	
Essex	147.9	↑
Lambton	136	
ESC LHIN	145.2	↑
Ontario	131.2	

Cancer Mortality Tables

Age Standardized Cancer Mortality - All Cancers (ICD-10 C00-C97), rate per 100,000 population, three year average, 2001

Planning Area	Both Sexes		Males		Females	
	Rate	Sign. Diff.	Rate	Sign. Diff.	Rate	Sign. Diff
Chatham-Kent	191.2	↑	244.6	↑	158.2	
Essex	192.0	↑	234.1	↑	164.9	↑
Lambton	192.2	↑	245.4	↑	157.3	
ESC LHIN	191.8	↑	238.9	↑	161.7	↑
Ontario	176.2		216.2		148.9	

Age Standardized Cancer Mortality - Lung Cancer (ICD-10 C33-C34), rate per 100,000 population, three year average, 2001

Planning Area	Both Sexes		Males		Females	
	Rate	Sign. Diff.	Rate	Sign. Diff.	Rate	Sign. Diff.
Chatham-Kent	48.4		67.2		35.7	
Essex	52.6	↑	69.5	↑	41.0	↑
Lambton	58.8	↑	73.1	↑	48.5	↑
ESC LHIN	53.3	↑	70.0	↑	41.7	↑
Ontario	43.8		57.7		33.3	

Age Standardized Cancer Mortality - Colorectal Cancer (ICD-18-C21), rate per 100,000 population, three year average, 2001

Planning Area	Both Sexes		Males		Females	
	Rate	Sign. Diff.	Rate	Sign. Diff.	Rate	Sign. Diff.
Chatham-Kent	15.7		21.5		11.2	
Essex	19.7		22.9		17.0	
Lambton	17.1		24.3		11.8	
ESC LHIN	18.3		23.0		14.7	
Ontario	18.4		23.3		14.6	

Age Standardized Cancer Mortality - Female Breast Cancer (ICD-10 C50), rate per 100,000 population, three year average, 2001

Planning Area	Females	
	Rate	Sign. Diff.
Chatham-Kent	26.5	
Essex	24.1	
Lambton	27.9	
ESC LHIN	25.4	
Ontario	25.3	

Age Standardized Cancer Mortality - Prostate Cancer (ICD-10 C61) rate per 100,000 population, three year average, 2001

Planning Area	Males	
	Rate	Sign. Diff.
Chatham-Kent	24.5	
Essex	26.3	
Lambton	30.2	
ESC LHIN	26.9	
Ontario	25.4	

Potential Years of Life Lost - Cancer

Potential Years of Life Lost (PYLL) - All Cancers (ICD-10 C00-C97), rate per 100,000 population aged 0 to 74, three year average, 2001

Planning Area	Both Sexes		Males		Females	
	Rate	Sign. Diff.	Rate	Sign. Diff.	Rate	Sign. Diff.
Chatham-Kent	2,018.2	↑	2,095.8	↑	1,939.9	↑
Essex	1601.0	↑	1578.9	↑	1,623.7	↑
Lambton	1,816.5	↑	1,883.1	↑	1,794.8	↑
ESC LHIN	1,718.4	↑	1,731.0	↑	1,705.5	↑
Ontario	1505.0		1,534.5		1,475.5	

Potential Years of Life Lost (PYLL) - Lung Cancer Deaths (ICD-10 C33-C34) rate per 100,000 population aged 0 - 74 years, three year average, 2001

Planning Area	Both Sexes		Males		Females	
	Rate	Sign. Diff.	Rate	Sign. Diff.	Rate	Sign. Diff.
Chatham-Kent	464	↑	496.9	↑	430.7	↑
Essex	421.7	↑	462.1	↑	380.1	↑
Lambton	562.4	↑	585.3	↑	539.4	↑
ESC LHIN	458.1	↑	493.4	↑	422.2	↑
Ontario	353.5		404.2		302.5	

Potential Years of Life Lost (PYLL) - Colorectal Cancer Deaths (ICD-10 C18-C21), rate per 100,000 population aged 0 - 74, three year average, 2001

Planning Area	Both Sexes		Males		Females	
	Rate	Sign. Diff.	Rate	Sign. Diff.	Rate	Sign. Diff.
Chatham-Kent	132.8		197.5	↑	67.5	↓
Essex	130.3		147.1		112.9	
Lambton	122.8		177.5	↑	67.9	↓
ESC LHIN	129.2		162.1		95.6	↓
Ontario	130.2		152.6		107.8	

Potential Years of Life Lost (PYLL) - Female Breast Cancer Deaths (ICD-10 C50), rate per 100,000 population aged 0 - 74, three year average, 2001

Planning Area	Females	
	Rate	Sign. Diff.
Chatham-Kent	419.5	↑
Essex	336.9	
Lambton	419.9	↑
ESC LHIN	368.7	↑
Ontario	330.3	

Potential Years of Life Lost (PYLL) - Prostate Cancer Deaths (ICD-10 C61) rate per 100,000 population aged 0 - 74, three year average, 2001

Planning Area	Males	
	Rate	Sign. Diff.
Chatham-Kent	43.0	
Essex	49.0	
Lambton	58.3	
ESC LHIN	49.9	
Ontario	51.6	

Observations

- Incidence for all invasive primary sites, for males across ESC LHIN is significantly higher than the province
- The incidence rate for females for all invasive primary sites is not significantly different than the province
- The incidence rate for bronchus and lung cancer is significantly higher for males and females in Essex and Lambton, and although higher than the province in Chatham-Kent, is not considered to be statistically significant
- The incidence rates of colon, rectum and recto sigmoid junction cancers, and breast cancer are not significantly different than the province
- The incidence of prostate cancer in Essex is significantly higher than the province. The rate in Chatham-Kent is highly variable and although it is higher than the province, it is not considered to be significant
- The age standardized mortality rate for all cancers is significantly higher than Ontario for both sexes taken together for Chatham-Kent, Essex and Lambton. Rates for males are significantly higher across the entire ESC LHIN, while rates for females in Chatham-Kent and Lambton are not considered to be significantly higher than Ontario
- Mortality rates for lung cancer are significantly higher for males and females for Essex and Lambton
- Mortality rates for colorectal cancer, breast and prostate are not significantly different than the province
- It should be noted that while the incidence of prostate cancer in Essex was significantly higher than the province, the mortality rate is not, which may indicate a higher degree of screening
- Potential years of life lost are significantly higher for ESC LHIN males and females for all cancer deaths and lung cancer deaths
- PYLL is significantly higher for Chatham-Kent and Lambton males for colorectal cancer deaths
- PYLL is significantly lower for Chatham-Kent and Lambton females for colorectal cancer deaths
- PYLL is significantly higher for females in Chatham-Kent and Lambton for breast cancer

1.7 Mammography Screening

Definition

- Proportion of women age 50-69, who reported ever having a mammogram, and within the past two years

Significance/Uses

- Breast cancer is among the leading causes of mortality for Ontario women
- The incidence of breast cancer is increasing. Since there are currently no established methods of breast cancer prevention, mortality reduction depends on early detection and appropriate treatment
- The Canadian Task Force on Preventive Health Care recommends regular breast screening with mammography and clinical breast examinations every 1-2 years for women age 50-69. Health Canada's National Committee for the Canadian Breast Cancer Screening Initiative recommends that all women

between the ages of 50-69 have a screening mammogram every two years

- Useful in planning preventive and promotional interventions
- Indicates access to breast screening services and useful for identifying potential target groups
- Comparison to mandatory health program guidelines
- Comparison over time and across place

Limitations

- Screening mammography is conducted on a voluntary basis and not having a recent mammogram is not necessarily evidence of lack of access. There is a potential for recall bias in the self-reported utilization

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Mammogram within the Past Two Years, 2005

females aged 50 to 69

	Received routine screening mammogram within the last 2 years		Received mammogram within the last 2 years for other reasons		No mammogram for at least 2 years	
Residence	**Number**	**%**	**Number**	**%**	**Number**	**%**
Chatham-Kent	6,104	58.6	2,390	22.9	1,659	15.9
Essex	27,916	61.9	6,949	15.4	9,210	20.4
Lambton	8,280	60.2	2,009	14.6	3,248	23.6
ESC LHIN	42,300	61.0	11,348	16.4	14,117	20.4
Ontario	708,324	53.0	237,741	17.8	348,739	26.1

Mammogram within the Past Two Years, 2005

females aged 50 to 69

	Received routine screening mammogram within the last 2 years		Received mammogram within the last 2 years for other reasons		No mammogram for at least 2 years	
Residence	**Change to reach Ontario %**	**Ratio**	**Change to reach Ontario %**	**Ratio**	**Change to reach Ontario %**	**Ratio**
Chatham-Kent	(583)	1.11	(537)	1.29	1,059	0.61
Essex	(4,005)	1.17	1,076	0.87	2,562	0.78
Lambton	(992)	1.14	110	0.82	340	0.90
ESC LHIN	(5,581)	1.15	977	0.92	3,961	0.78
Ontario	-	1.00	-	1.00	-	1.00

Observations

- Overall, a higher proportion of women in ESC LHIN report having a routine screening mammogram within the past two years than Ontario (61% compared to 53%)
- The highest rate in ESC LHIN is in Essex County (62%) and lowest in Chatham-Kent (59%)
- The numbers in the category "for other reasons" must be used with caution since there is high variability
- Proportion of women who reported not having a mammogram for at least two years appears to be similar to the province for Essex, higher for Lambton at 24% and appears to be much lower for Chatham-Kent, but the number must be used with caution due to high variability

1.8 Pap Smear Testing

Definition

- Proportion of women age 18+, who reported ever screening for cervical cancer ever and within the past three years

Significance/Uses

- The Task Force for Cervical Cancer Screening recommends that all women age 18+, who have had sexual intercourse be screened for cervical cancer. It recommends an initial pap test, repeated after one year, followed by a test (if the first two are normal) every three years to the age of 69
- Screening is recognized as an effective means of reducing cervical cancer mortality
- Cervical cancer is completely treatable if detected early
- Useful in identifying high-risk groups based on age and SES
- Useful in planning preventive and promotional interventions
- Indicates access to preventive health services
- Comparison to mandatory health program benchmarks

Limitations

- This indicator should be used in conjunction with the number of sex partners and the age at first intercourse to assess women's risk of cervical cancer
- The denominator for the rate includes women who have had hysterectomies, even though they are no longer at risk for cervical cancer. The inclusion of these women will inflate the percentage of women who were not screened
- Failure to have a recent test is not necessarily evidence of lack of access
- There is the potential for recall bias

Pap Smear

females aged 18 to 69

	Within the last 3 years		3 or more years ago		Never	
Residence	Number	%	Number	%	Number	%
Chatham-Kent	26,620	74.9	5,589	15.7	2,777	7.8
Essex	98,352	72.7	20,188	14.9	13,270	9.8
Lambton	32,097	74.1	7,959	18.4	3,206	7.4
ESC LHIN	157,069	73.3	33,736	15.7	19,253	9.0
Ontario	3,135,279	72.9	551,941	12.8	508,664	11.8

Pap Smear

females aged 18 to 69

	Within the last 3 years		3 or more years ago		Never	
Residence	Change to reach Ontario %	Ratio	Change to reach Ontario %	Ratio	Change to reach Ontario %	Ratio
Chatham-Kent	(727)	1.03	(1,031)	1.23	1,424	0.66
Essex	228	1.00	(2,834)	1.16	2,724	0.83
Lambton	(525)	1.02	(2,401)	1.44	1,916	0.63
ESC LHIN	(1,023)	1.01	(6,265)	1.23	6,064	0.76
Ontario	-	1.00	-	1.00	-	1.00

Observations

- The proportion of females aged 18 – 69 who reported having a Pap smear within the past three years is higher than the province in Chatham-Kent (75%) and Lambton (74%) while Essex is similar to the province at approximately (73%)
- An average of (16%) of ESC LHIN residents reported having a Pap smear three or more years ago compared with 13% for Ontario

1.9 Motor Vehicles Crashes

Definition

- Number of motor vehicle crashes causing injury or death, occurring in the ESC LHIN District and Ontario. Types of injuries resulting from motor vehicle crashes in Ontario

Significance/Uses

- Motor vehicle crashes are a potentially avoidable cause of hospitalization, death and disability. Crashes can result in significant health care and indirect personal and social costs due to disability
- The Ontario Road Safety Annual Reports count crashes by place of occurrence, which is usually the location of the initial health care encounter. MOHLTC data provides information by patient residence, which provides information on the location of on-going care
- Index of the impact of crashes on the health care system
- Useful for planning prevention programs
- A primary cause of death and hospitalization among teens and young adults and a major contributor of PYLL

Limitations

- The Ontario Road Safety Annual Report tracks motor vehicle crashes by place of occurrence, therefore the appropriate population denominator for a rate is unclear
- Numbers reflect only those crashes that are reported to police and therefore may underestimate the actual number of crashes
- Information on diagnoses and procedures are not provided for the district; however, it is unlikely that the local data would differ significantly from the Ontario data
- MTO and MOHLTC data provide different types of information. These administrative sources collect information in different ways for different reasons; therefore the numbers are not directly comparable

Source

- Ministry of Transportation Ontario Road Safety Annual Report 2003-2004

Number of Motor Vehicle Crashes Occurring by County, ESC LHIN & Ontario by Type - 2003 - 2004

Type	Chatham-Kent		Essex		Lambton		ESC LHIN		Ontario	
	2003	2004	2003	2004	2003	2004	2003	2004	2003	2004
Total collisions	1,623	1,574	8,311	7,379	2,088	1,998	12,022	10,951	246,463	231,548
Fatal collisions	12	14	24	27	14	19	50	60	754	718
Personal injury	439	425	1,570	1,513	414	433	2,423	2,371	52,757	49,948
Property damage	1,172	1,135	6,717	5,839	1,660	1,546	9,549	8,520	192,952	180,882
Persons killed	14	19	24	30	16	21	54	70	831	799
Persons injured	641	639	2,287	2,164	606	672	3,534	3,475	77,879	73,008
% on Provincial Highways	12.0	12.3	4.2	3.9	14.7	15.6	12.5	7.3	17.3	17.5
Motor vehicle registration	86,388	86,327	261,410	263,030	96,802	96,849	444,600	446,206	7,868,553	8,655,597

Observations

- In ESC LHIN, the volume of total collisions declined in 2004, as it has in Ontario
- The total number of fatal collisions has increased slightly, and so has the number of persons killed
- The largest proportion (72 – 79%) of motor vehicle crashes in the three planning areas were associated with property damage. Relatively larger proportions of crashes in Chatham Kent (12%) and Lambton (16%) compared with Essex (4%) occurred on provincial highways, but the proportion was not as large as for Ontario (18%)
- Although not shown here, for Ontario as a whole, the most common types of injuries involving hospitalization were fractures, internal injuries and open wounds
- There were 5,646 admissions (following motor vehicle accidents), to Ontario hospitals in 2004, accounting for 51,938 days of care. Average length of stay for these patients was approximately 9.2 days
- The leading surgical procedures provided for patients hospitalized following a motor vehicle crash were for reduction of fractures and dislocations, procedures on head, brain and cerebral meninges, chest wall, and subcutaneous and skin tissue
- Although updated numbers for ESC LHIN are not available at time of printing, it was noted earlier in this report that motor vehicle crashes were identified as one of the leading causes of Potential Years of Life Lost (PYLL) in ESC LHIN

HEALTH SERVICES UTILIZATION

SECTION 2

2.1 Ambulance Service Utilization

Definition

- Number of ambulance transports by priority status

Priority Status

1. Non-emergency - Transport of a patient, who may or may not need medical supervision, between hospitals, long term care homes, clinics, residences or other institutions, where there isn't a specific time requirement. These calls can be deferred for emergency calls
2. Scheduled Transfer – Transfer of a patient who may or may not need medical supervision to hospitals, long term care homes, clinics, residences and other institutions for a scheduled event (appointment, medical test, etc.). These calls are booked in advance
3. Non Life-threatening – Calls that prompt an immediate response for a non-life threatening condition to provide immediate care and transportation to hospital
4. Life Threatening – Calls which prompt an immediate response to provide immediate intervention and transport for life-threatening or potentially life-threatening conditions, requiring the response of advance level paramedics
8. Stand-by – To provide full coverage for the area when an ambulance is out-of-service or unable to respond (priority 7), another ambulance provides coverage beyond its usual service area

Significance/Uses

- Indicator of volume and types of ambulance service utilization
- Key indicator of emergency care response available to the community
- Measures relative severity of patients transported by ambulance services
- Protective stand-by calls provide an indication of pressure on existing resources

Limitations

- Transfer of ambulance service funding to municipalities may affect service capacity and consistency of ambulance report system
- Ambulance transports or pickups in an area may be for non-residents; therefore calculation of rates is not appropriate since the population denominator is unknown

- Does not capture non-ESC LHIN ambulance activity to ESC LHIN hospitals or for transport of ESC LHIN residents
- Protective stand by calls were not included in previous reports therefore proportions of calls by priority may differ compared to previous reports

Source

- EMS, Municipality of Chatham-Kent, Essex/Windsor, Lambton County

Ambulance Transports Trending by Call Priority
January – December 2003-2005*

Priority	2003		2004		2005	
	#	%	#	%	#	%

Chatham-Kent

Code 1 - Non-emergency	4,144	30.3	700	6.6	567	5.1
Code 2 - Scheduled transfer	1,208	8.8	374	3.5	277	2.5
Code 3 - Non-life threatening	2,456	17.9	1,891	17.7	1,749	15.8
Code 4 - Life threatening	5,876	42.9	7,713	72.2	8,460	76.5
Total	**13,684**		**10,678**		**11,053**	

Essex

Code 1 - Non-emergency	9,992	19.9	6,537	14.1	4,259	9.1
Code 2 - Scheduled transfer	2,718	5.4	2,081	4.5	1,644	3.5
Code 3 - Non-life threatening	13,930	27.8	13,803	29.8	13,843	29.7
Code 4 - Life threatening	23,464	46.8	23,905	51.6	26,848	57.6
Total	**50,104**		**46,326**		**46,594**	

Lambton

Code 1 - Non-emergency	4,425	30.1	985	9.6	860	8.5
Code 2 - Scheduled transfer	1,602	10.9	428	4.2	281	2.8
Code 3 - Non-life threatening	2,458	16.7	1,726	16.9	1,532	15.1
Code 4 - Life threatening	6,194	42.1	7,092	69.3	7,479	73.7

ESC LHIN

Code 1 - Non-emergency	18,561	23.6	8,222	12.2	5,686	8.4
Code 2 - Scheduled transfer	5,528	7.0	2,883	4.3	2,202	3.2
Code 3 - Non-life threatening	18,844	24.0	17,420	25.9	17,124	25.2
Code 4 - Life threatening	35,534	45.3	38,710	57.6	42,787	63.1
Total	**78,467**		**67,235**		**67,799**	

Source: EMS, Municipality of Chatham-Kent, Essex Windsor, County of Lambton

Excluded "stand by"

Observations

- In Erie St. Clair, the total number of calls decreased by almost 17% from 2003 to 2004 with volumes for 2005 only slightly increased from 2004
- The proportion of Code 4 transports continues to increase, while Code 3s remained relatively unchanged
- Code 1 and 2 continued to decrease, likely reflecting an increase in the use of private providers for non-emergency ambulance transports
- 88% of transports in 2005 were for Codes 3 and 4, with code 4s representing the highest volume at 63%
- In Chatham-Kent, there has been a 24% decrease in total calls from 2003 – 2005, the proportion of Code 4s continues to increase, while the Code 3s have decreased slightly and Code 1 and 2 continue to decrease. 92% of transport calls in 2005 were for Code 3 and Code 4 priority cases (urgent and life-threatening)
- In Essex, there has been a 7.5% decrease in total calls from 2003 – 2005. The proportion of Code 4s continues to increase, Code 3s remain relatively unchanged and Code 1 and 2 are decreasing. 87% of transport calls in 2005 were for Code 3 and Code 4 priority cases and 30% of calls were Code 3 priority (urgent), higher than in either Chatham-Kent or Lambton
- In Lambton, there has been a 44% decrease in total calls from 2003 – 2005. Code 4s have continued to increase, while Code 3s have decreased slightly and Code 1 and 2s continue to decrease. 89% of transport calls in 2005 were for Code 3 and Code 4 priority cases

2.2 Emergency Department (ER) Utilization

Definition

- Number and characteristics of visits to ESC LHIN hospital emergency departments (ER) in a fiscal year
- Number and characteristics of visits by ESC LHIN residents to Ontario Hospital ERs in a fiscal year

Significance/Uses

- Indicator of in-hospital emergency care available to an area population
- Comparisons over time and place
- Indicator of caseload handled by hospital ERs
- Triage level is an indicator of the relative severity and time sensitivity of cases treated in ER
- Use of ambulance services by ER patients provides an indication of ambulance traffic to the ER
- Utilization is a function of patient demand, availability of primary care and other urgent care services and the size and number of ERs
- Elapsed time in the ER is an indicator of the average caseload and access

Limitations

- Major trauma centres handle cases from outside the local area, which will influence area utilization
- Does not assess the appropriateness of the ER visit
- There have been some coding inconsistencies in the NACRS data and particularly in measurements of time used in the calculation of elapsed time in the ER; therefore time-based information should be interpreted with caution

Source

- CIHI NACRS Files PHPDB.

Emergency Department Visits, ESC LHIN Hospitals by County – Residents/Non-Residents 2003/04 – 2005/06

Year	# ER Visits	Residents		Non-Residents	
		#	%	#	%
Chatham-Kent Hospitals					
2003/04	66,566	59,745	89.8	6,821	10.2
2004/05	69,728	63,027	90.4	6,701	9.6
2005/06	67,930	61,256	90.2	6,674	9.8
Essex Hospitals					
2003/04	137,742	131,059	95.1	6,683	4.9
2004/05	141,643	134,906	95.2	6,737	4.8
2005/06	137,331	130,930	95.3	6,401	4.7
Lambton Hospitals					
2003/04	73,733	71,045	96.4	2,688	3.6
2004/05	78,516	75,710	96.4	2,806	3.6
2005/06	78,446	75,342	96.0	3,104	4.0
ESC LHIN Hospitals					
2003/04	278,041	261,849	94.2	16,192	5.8
2004/05	289,887	273,643	94.4	16,244	5.6
2005/06	283,707	267,528	94.3	16,179	5.7

Source: PHPDB, NACRS Database Semtember 2006

Observations

- Generally, total volumes of emergency department visits declined across ESC for 2005/06 after increasing in 2004/05 following the SARS outbreak in 2003/04
- Decreases were mainly in Essex and Chatham-Kent, while Lambton visits remained stable
- The majority of patients served within ESC ERs were local residents, with Essex residents accounting for 95% of the volumes within Essex hospitals, Lambton residents accounting for 96% of the total visits at Lambton hospitals and Chatham-Kent residents accounting for 90% of the visits at Chatham-Kent hospitals

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Emergency Department Visits to ESC LHIN Hospitals by County of Residence 2004/05 – 2005/06 (combined)

Patient Residence	Chatham-Kent Hospitals		Essex Hospitals		Lambton Hospitals		ESC LHIN Hospitals	
	# visits	%	# visits	%	# visits	%	# visits	%
Chatham-Kent	124,283	90.3	7,021	2.5	1,349	0.9	132,653	23.1
Essex	1,474	1.1	265,836	95.3	318	0.2	267,628	46.7
Lambton	9,192	6.7	242	0.1	151,052	96.2	160,486	28.0
Middlesex	471	0.3	480	0.2	825	0.5	1,776	0.3
Toronto	138	0.1	638	0.2	279	0.2	1,055	0.2
Out-of-Province	782	0.6	2,490	0.9	1,105	0.7	4,377	0.8
Other	1,318	0.9	2,267	0.8	2,034	1.3	5,619	0.9
Total	137,658	100.0	278,974	100.0	156,962	100.0	573,594	100.0

Source: PHPDB NACRS Database September 2006

Observations

- Close to 7% of the Emergency Department visits at Chatham Kent hospitals were by Lambton residents – the largest proportion of these at the Sydenham Campus in Wallaceburg. This is likely by Lambton residents who live in close proximity to Wallaceburg, including the Walpole Island population
- 1% of the total visits at Chatham Kent Emergency Departments were by Essex residents, with the remaining 2% of non-residents representing a variety of other areas
- 2.5% of Essex ER visits were by Chatham-Kent residents, with slightly less than 1% of Essex cases being from out of province
- In Lambton Emergency Departments, approximately 1% of visits were by Chatham-Kent residents, with less than 3% coming from other areas

Proportion of Visits Served in ESC LHIN Hospitals by Triage Level 2004/05 – 2005/06

Triage Level	Chatham-Kent		Essex		Lambton		ESC LHIN Hospitals	
	2004/05	2005/06	2004/05	2005/06	2004/05	2005/06	2004/05	2005/06
	%	%	%	%	%	%	%	%
Resuscitation	0.3	0.2	0.4	0.5	0.4	0.5	0.4	0.4
Emergent	7.4	7.6	12.7	13.8	8.3	8.0	10.2	10.7
Urgent	23.7	25.9	40.2	44.4	28.4	29.8	33.1	35.9
Less Urgent	55.9	57.1	34.4	31.5	55.2	53.4	45.2	43.7
Non Urgent	12.8	9.2	12.2	9.9	7.6	8.2	11.1	9.3
Total Visits	69,728	67,930	141,643	137,331	78,516	78,446	289,887	283,707

Source: PHPDB NACRS Database September 2006

Observations:

- The largest proportion of cases treated in ESC LHIN had less urgent triage levels, followed by urgent and non-urgent cases
- Less than 1% of cases required resuscitation or had life-threatening conditions
- In 2005/06, 9% of the cases in Chatham-Kent, 10% in Essex and 8% in Lambton were non-urgent cases who might be better served elsewhere if care were available. It should be noted that the volume of non-urgent cases decreased 2 – 3% over 2004/05 in Chatham-Kent and Essex
- Less urgent cases represent over half of Chatham-Kent and Lambton volumes in 2005/06 (57% in Chatham-Kent and 53% in Lambton), while representing only 32% of Essex volumes
- The highest volume of cases in Essex hospitals were classified as urgent (44%) compared with 26% in Chatham-Kent and 30% in Lambton
- Emergent cases were higher in Essex at 14% compared with approximately 8% in Chatham-Kent and Lambton

Emergency Department Visits Involving Ambulance Utilization, ESC LHIN Hospitals 2004/05 – 2005/06

	2004/05		2005/06	
Planning Area	Arrived by Ambulance		Arrived by Ambulance	
	#	%	#	%
Chatham-Kent	6,249	9.0	6,157	9.1
Essex	24,344	17.2	25,371	18.5
Lambton	4,903	6.2	5,672	7.2
ESC LHIN	35,496	12.2	37,200	13.1

Source: PHPDB NACRS Database September 2006

Observations

- A higher proportion of Essex ER patients arrived by ambulance (18.5% in 2005/06, compared with 9% in Chatham-Kent and 7% in Lambton)

Proportion of Emergency Visits by Discharge Disposition, ESC LHIN Hospitals 2004/05 – 2005/06

Discharge Disposition	Chatham-Kent		Essex		Lambton		ESC LHIN	
	2004/05	2005/06	2004/05	2005/06	2004/05	2005/06	2004/05	2005/06
	%	%	%	%	%	%	%	%
Discharged to place of residence (includes home and residential institution)	87.2	87.2	78.2	76.9	88.9	89.6	83.2	82.9
Left without being seen	3.9	3.6	4.4	5.5	1.8	1.4	3.6	3.9
Left prior to completion of treatment	0.4	0.9	2.0	2.2	0.4	0.8	1.2	1.5
Admitted as an in-patient	7.7	7.5	14.0	14.0	7.9	7.3	10.8	10.6
Transferred to another facility	0.5	0.5	1.0	1.1	0.4	0.4	0.7	0.7
Death	0.1	0.1	0.2	0.2	0.1	0.1	0.1	0.2
Transferred to another ambulatory department	0.2	0.2	0.2	0.2	0.4	0.4	0.3	0.3

Source: PHPDB NACRS Database September 2006

Note: "Discharged to place of residence" includes patients who were sent back to nursing homes and other residential care. Effective with 2005/06 data, these patients are captured in a separate category and will be able to be tracked in this fashion in future years. In this report, these categories were rolled together for comparative purposes.

Observations

- The vast majority of ER patients in Chatham-Kent and Lambton were sent home following their visit (87 and 90% respectively) while 77% of Essex patients were sent home
- 14% of Essex patients were admitted to inpatient care compared to 7.5 and 7.3% of Chatham-Kent and Lambton ER patients
- Approximately 4% of patients left without being seen at Chatham-Kent hospitals compared with 5.5% in Essex hospitals and only 1.4% in Lambton hospitals

Average Time Elapsed to Key Events in the Emergency Visit, ESC and Ontario Hospitals 2003/04 – 2005/06

Year	Chatham-Kent Hospitals	Essex Hospitals	Lambton Hospitals	ESC LHIN Hospitals	Ontario Hospitals
Average Time from Triage to Physician Assessment					
2003/04	1 hour 22 min.	1 hour 29 min.	41 min.	1 hour 12 min.	57 min.
2004/05	1 hour 22 min.	1 hour 19 min.	44 min.	1 hour 7 min.	1 hour 1 min.
2005/06	1 hour 26 min.	1 hour 54 min.	44 min.	1 hour 26 min.	1 hour 24 min.
Average Time from Assessment to Discharge					
2003/04	53 min.	2 hours 12 min.	1 hour 18 min.	1 hour 40 min.	2 hours 26 min.
2004/05	56 min.	2 hours 36 min.	1 hour 10 min.	1 hour 50 min.	2 hours 26 min.
2005/06	57 min.	2 hours 20 min.	1 hour 13 min.	1 hour 41 min.	2 hours 7 min.
Average Time from Triage to Discharge					
2003/04	2 hours 12 min.	3 hours 34 min.	1 hour 58 min.	2 hours 46 min.	3 hours 13 min.
2004/05	2 hours 14 min.	3 hours 52 min.	1 hour 54 min.	2 hours 53 min.	3 hours 17 min.
2005/06	2 hours 20 min.	4 hours 6 min.	1 hour 53 min.	3 hours 2 min.	3 hours 19 min.

Source: PHPDB NACRS Database, September 2006

Note: There are some issues with lack of standardization and consistency in recording of times of key events, therefore caution should be exercised in interpreting trends.

Observations

- The smaller proportion of patients who left the Lambton ERs without being seen may be related to the shorter average times from triage to physician assessment

Emergency Department Visits by ESC LHIN Residents to Ontario Hospitals 2003/04 – 2005/06

Year	ER Visits	Local Hospitals		Out-of-County Hospitals	
	#	#	%	#	%
Chatham-Kent Residents					
2003/04	70,009	59,745	85.2	10,354	14.8
2004/05	74,001	63,027	85.2	10,974	14.8
2005/06	71,800	61,256	85.3	10,544	14.7
Essex Residents					
2003/04	135,534	131,059	96.7	4,475	3.3
2004/05	139,572	134,906	96.7	4,666	3.3
2005/06	136,004	130,930	96.3	5,074	3.7
Lambton Residents					
2003/04	85,082	71,045	83.5	14,037	16.5
2004/05	90,222	75,710	83.9	14,512	16.1
2005/06	90,003	75,342	83.7	14,661	16.3
ESC LHIN Residents					
2003/04	290,625	261,849	90.1	28,776	9.9
2004/05	303,795	273,643	90.1	30,152	9.9
2005/06	297,807	267,528	89.8	30,279	10.2

Source: PHPDB NACRS Database September 2006

Observations for 2005/06

- 90% of ESC resident ER visits are made to ESC LHIN ERs
- Chatham Kent residents made 71,800 ER visits in Ontario hospitals, with 15% of these visits taking place in other county hospitals
- Essex residents made over 136,000 ER visits with only 3.7% of these visits taking place outside of Essex
- Lambton residents made 90,000 visits to Ontario Emergency Departments, with 16% of these visits taking place outside of Lambton

Emergency Department Visits by ESC LHIN Residents by County of Hospital 2005/06

Hospital Location	Chatham-Kent Residents		Essex Residents		Lambton Residents		ESC LHIN Residents	
	#	%	#	%	#	%	#	%
Chatham-Kent	61,256	85.3	776	0.6	4,513	5.0	66,545	22.4
Essex	3,427	4.8	130,930	96.3	108	0.1	134,465	45.2
Lambton	703	1.0	180	0.1	75,342	83.7	76,225	25.6
Middlesex	5,303	7.4	1,046	0.8	6,933	7.7	13,282	4.5
Toronto	98	0.1	343	0.3	139	0.1	580	0.2
Huron	64	0.1	211	0.1	1,481	1.7	1,756	0.6
All Other	949	1.3	2,518	1.9	1,487	1.7	4,954	1.6
Total	**71,800**	100	**136,004**	100	**90,003**	100	**297,807**	100

Source: PHPDB, NACRS Database, September 2006

Observations

- 7% of ER visits by Chatham-Kent residents took place in Middlesex hospitals, 5% in Essex hospitals, 1% in Lambton hospitals and the remaining 2% spread among all other Ontario locations
- 4% of ER visits by Essex residents occurred outside of Essex County hospitals
- Almost 8% of ER visits by Lambton residents occurred in Middlesex hospitals, 5% in Chatham-Kent, and close to 2% in Huron hospitals

2.3 Acute In-patient Utilization

Definition

- Acute inpatient separations, patient days and average length of stay (ALOS) for ESC LHIN hospitals 2004/05
- Top 10 program cluster categories for ESC LHIN Hospitals 2004/05
- Acute inpatient separations patient days and ALOS for ESC LHIN residents from Ontario hospitals per 1,000 area resident population 2004/05

Significance/Uses

- Indicator of acute inpatient volumes
- Acute inpatient care represents a major part of hospital expenditures. This indicator may serve as a proxy to measure relative allocation of hospital resources
- Permits comparisons over time
- Identifies the primary users of local hospitals and where local residents go for acute hospital care

Limitations

- Captures utilization patterns but not population needs
- Adjustment for factors such as age, sex, disease complexity etc is required to allow fair comparison between areas
- Separations reflect treatment episodes for each facility, transfers between facilities will contribute multiple separations
- Program type is based on the medical/surgical classification of specific CMGs
- Age standardized separation rates available at ESC LHIN level only

Source

- Acute Care Utilization Report, ESC LHIN, Health System Intelligence Project, April 2006

Selection Criteria

- All acute cases treated in Ontario hospitals
- Excludes newborns (PCC=11), Acute Psychiatry (PCC=20)

Acute Separations, Acute Days, Acute ALOS, ESC LHIN & Ontario Hospitals, 2004/05

	Acute Separations	Acute Days	Acute ALOS
Chatham-Kent	8,501	41,908	4.9
Essex	30,594	155,909	5.1
Lambton	9,662	51,004	5.3
ESC LHIN	48,757	248,821	5.1
Ontario	944,650	5,200,536	5.5

Source: Acute Care Utilization Report, Health System Intelligence Report March 2006

Observations

- In 2004/05 there were 48,757 acute separations with 248,821 discharge days. These figures accounted for 5.2% of the acute separations and 4.8% of the acute days from Ontario hospitals
- The acute average length of stay (5.1 days) in ESC LHIN hospitals was slightly shorter than the acute average length of stay (5.5 days) in Ontario hospitals
- 98.8% of acute separations from ESC LHIN Hospitals were by ESC LHIN residents. SW LHIN (0.4%) and out-of-province (0.2%) were the next most common areas of patient origin for separations from ESC LHIN

Hospitals

- ESC LHIN hospitals had a higher proportion of medical separations (69.8%) compared to Ontario hospitals (65.8%)
- Chatham-Kent Health Alliance (CKHA) accounted for 17% of the total separations and patient days in the ESC LHIN
- CKHA had the lowest acute average length of stay in ESC LHIN – 4.9 days
- Essex hospitals accounted for 63% of the total separations and patient days in the ESC LHIN
- Average length of stay was also below the province at 5.1 days, slightly higher than Chatham-Kent
- Bluewater Health accounted for 20% of total separations and patient days in the ESC LHIN
- Average length of stay for Lambton is the highest in the LHIN at 5.3, but still below the Ontario ALOS of 5.5

Acute Separations, Patient Days, and ALOS by Hospital Site 2004/2005

	Separations	Days	ALOS
Chatham-Kent			
CKHA, Public General	6,460	33,266	5.1
CKHA, St. Joseph's	628	1,231	2.0
CKHA, Sydenham	1,413	7,411	5.2
Total	**8,501**	**41,908**	**4.9**
Essex			
Hotel Dieu Grace	12,419	71,240	5.7
Leamington District Memorial Hospital	3,301	14,550	4.4
Windsor Regional	14,874	70,119	4.7
Total	**30,594**	**155,909**	**5.1**
Lambton			
Bluewater Health, CEE Petrolia	734	5,738	7.8
Bluewater Health, Sarnia	8,928	45,266	5.1
Total	**9,662**	**51,004**	**5.3**

Source: Acute Care Utilization Report, Health System Intelligence Project, March 2006

The previous table shows the breakdown of separations, patient days and average length of stay by hospital site for each county. It is included here to provide the reader with an idea of the volume of acute inpatients seen at each physical site within the ESC LHIN as well as the impact of lengths of stay at each site when looking at aggregated data. Conclusions should not be drawn on the basis of length of stay without also looking at case mix within each physical location.

Top 10 Program Cluster Categories ESC LHIN Hospitals by County and Ontario 2004/2005

Chatham-Kent			Essex			Lambton			Erie St. Clair			Ontario
PCC	# Cases	% of Total	PCC	# Cases	% of Total	PCC	# Cases	% of Total	PCC	# Cases	% of Total	% of Total
Cardiology	1,237	13.6	Obstetrics	5,094	15.3	Cardiology	1,541	17.4	Obstetrics	7,246	13.7	15.6
Obstetrics	1,149	12.7	Cardiology	3,507	10.6	Gastro/ Hepatobiliary	1,031	9.8	Cardiology	6,285	11.9	10.6
Gastro/ Hepatobiliary	1,050	11.6	Gastro/ Hepatobiliary	2,817	8.5	Obstetrics	1,003	9.5	Gastro/ Hepatobiliary	4,898	9.3	7.9
Pulmonary	860	9.5	Gen. Surg.	2,670	8.0	Gen. Surg.	879	8.4	Pulmonary	4,288	8.1	7.6
Gen. Med.	675	7.4	Psychiatry	2,633	7.9	Psychiatry	850	8.1	Gen. Surg.	4,171	7.9	8.5
Gen. Surg.	622	6.9	Pulmonary	2,579	7.8	Pulmonary	849	8.1	Psychiatry	4,049	7.7	5.8
Psychiatry	566	6.2	Orthopaedics	2,230	6.7	Orthopaedics	668	6.4	Orthopaedics	3,376	6.4	6.1
Orthopaedics	478	5.3	Urology	1,588	4.8	Gen. Med.	656	6.2	Gen. Med.	2,711	5.1	5.9
Neurology	395	4.4	Trauma	1,438	4.3	Urology	600	5.7	Urology	2,522	4.8	3.9
Gynaecology	385	4.2	Gen. Med.	1,380	4.2	Trauma	413	3.9	Trauma	2,151	4.1	4.7

Source: Health System Intelligence Project, March 2006

Observations

- The top three PCCs in ESC were Obstetrics, Cardiology and Gastro/Hepatobiliary conditions. These three PCCs represent almost 35% of the total volume of cases in ESC LHIN
- ESC has a lower proportion of Obstetrics than Ontario, but a higher proportion of Cardiology, Gastro/ Hepatobiliary, Pulmonary, Psychiatry, Orthopaedics and Urology than Ontario
- In Chatham Kent, Cardiology is the highest percentage of cases, followed by Obstetrics, Gastro/ Hepatobiliary, Pulmonary and General Medicine
- In Essex, Obstetrics is the highest percentage of cases, followed by Cardiology, Gastro/Hepatobiliary, General Surgery and Psychiatry
- In Lambton as in Chatham Kent, Cardiology is the highest percentage of cases, followed by Gastro/ Hepatobiliary, Obstetrics, General Surgery and Psychiatry

Acute Separations, Days, & Average Length of Stay (ALOS), by Area of Residence, ESC LHIN & Ontario Residents, 2004/05

	Acute Separations	Acute Days	Acute ALOS
Chatham-Kent	11,052	55,341	5.0
Essex	32,687	168,250	5.1
Lambton	12,683	69,062	5.4
ESC LHIN	56,422	292,653	5.2
Ontario	934,669	5,142,030	5.5

Source: Acute Care Utilization Report, Health System Intelligence Project March 2006

Observations

- In 2004/2005, there were 56,422 acute separations and 292,653 acute days for ESC residents (from all Ontario hospitals)
- These separations accounted for 6% of the acute separations and 5.7% of the acute days for Ontario residents
- The acute average length of stay for ESC residents is slightly lower than that of Ontario residents (5.2 compared with 5.5)
- Although the table is not shown, 85.4% of ESC acute in-patients were treated in ESC Hospitals, with the South West LHIN being the next most common location for residents' hospitalizations (12.5%)
- Approximately 22% of Chatham-Kent resident hospitalizations occurred outside Chatham-Kent
- Approximately 7% of Essex resident hospitalizations occurred outside Essex County
- Approximately 24% of Lambton resident hospitalizations occurred outside Lambton County
- Although the table is not shown, ESC residents had similar proportions of medical and surgical separations as Ontario residents

Age-Standardized Acute Separation Rates per 1,000 Population & Crude Acute Day Rates per 1,000 Population, ESC LHIN & Ontario Residents, 2004/05

	Age-Standardized Acute Separation Rate	Crude Acute Day Rate
ESC LHIN Residents	82.4	453.6
Ontario Residents	72.5	414.9

Source: Acute Care Utilization Report, Health System Intelligence Project March 2006

- Significantly higher than provincial average based on assessment of 95% confidence intervals

Observations

- The age standardized acute separation rate for ESC residents was significantly higher than the rate for Ontario residents
- The crude acute day rate was approximately 9% higher than the rate for Ontario residents

2.4 Day Surgery Utilization

Definition

- Number of day surgery cases treated in ESC LHIN Hospitals
- Number of day surgery cases for ESC LHIN residents from Ontario hospitals

Significance/Uses

- Indicator of cost efficient delivery of surgical procedures that can be performed on an ambulatory basis
- Use of day surgery allows reduction in the number of acute hospital beds without compromising surgical care

Limitations

- Adjustment for factors such as age and sex are required to allow for a fair comparison to other areas
- In 2003/04 coding of day surgery moved from the DAD to the NACRS database. Procedures included here have the ambulatory case type SDN (Surgical Day/Night) care and include all procedures completed in an operating or endoscopy room
- May include multiple procedures for an individual

Source

- CIHI NACRS Files PHPDB

Day Surgery Procedures Performed in ESC LHIN Hospitals
2003/04 – 2005/06

Year	Total Day Procedures	Residents		Non-Residents	
	#	#	%	#	%
Chatham-Kent Hospitals					
2003/04	8,651	7,962	92.0	689	8.0
2004/05	8,944	8,309	92.9	635	7.1
2005/06	11,212	10,114	90.2	1,098	9.8
Essex Hospitals					
2003/04	39,206	36,620	93.4	2,586	6.6
2004/05	39,537	36,942	93.4	2,595	6.6
2005/06	41,182	38,880	94.4	2,302	5.6
Lambton Hospitals					
2003/04	12,561	11,938	95.0	623	5.0
2004/05	12,636	11,938	94.5	698	5.5
2005/06	13,185	12,501	94.8	684	5.2
ESC LHIN Hospitals					
2003/04	60,418	56,520	93.6	3,898	6.4
2004/05	61,117	57,189	93.6	3,928	6.4
2005/06	65,579	61,495	93.8	4,084	6.2

Source: PHPDB, NACRS Database, September 2006

Observations

- Overall, the number of day surgery procedures has continued to increase from 2003/04 to 2005/06
- Over 90% of day surgery procedures performed in ESC LHIN hospitals were performed on ESC LHIN residents
- 10% of the day surgery procedures performed in Chatham-Kent hospitals were performed on non-residents of Chatham-Kent, while only 5% of procedures in Essex and Lambton hospitals were performed on non-residents of these counties

Proportion of Day Surgery Procedures in ESC LHIN Hospitals by County of Patient Residence 2005/06

Patient Residence	Chatham-Kent Hospitals		Essex Hospitals		Lambton Hospitals		ESC LHIN Hospitals	
	# visits	%	# visits	%	# visits	%	# visits	%
Chatham-Kent	10,114	90.2	1,111	2.7	422	3.2	11,647	17.8
Essex	315	2.8	38,880	94.4	45	0.3	39,240	59.8
Lambton	488	4.4	480	1.2	12,501	94.8	13,469	20.5
Middlesex	225	2.0	401	0.9	134	1.0	760	1.2
Toronto	2	0	20	0.1	3	0	25	0
Out-of-Province	0	0	112	0.3	8	0.1	120	0.2
Other	68	0.6	178	0.4	72	0.6	318	0.5
Total	11,212	100.0	41,182	100.0	13,185	100.0	65,579	100.0

Source: PHPDB, NACRS Database September 2006

Observations

- Of the 10% of Chatham-Kent day procedures performed on non-residents of Chatham-Kent, 4% were performed on Lambton residents, 3% on Essex residents, and 2% on Middlesex residents
- In Essex hospitals, approximately 3% of the procedures were performed on Chatham-Kent residents and 1% on Lambton residents
- In Lambton hospitals, 3% of day surgery procedures were performed on Chatham-Kent residents and 1% on Middlesex residents

Day Surgery Procedures Performed on ESC LHIN Residents in Ontario Hospitals 2003/04 – 2005/06

Year	Total Day Procedures	Local Hospitals		Out-of-County Hospitals	
	#	#	%	#	%
Chatham-Kent Hospitals					
2003/04	10,883	7,962	73.2	2,921	26.8
2004/05	11,540	8,309	72.0	3,231	28.0
2005/06	13,251	10,114	76.3	3,137	23.7
Essex Hospitals					
2003/04	38,688	36,620	94.7	2,068	5.3
2004/05	39,360	36,942	93.9	2,418	6.1
2005/06	41,569	38,880	93.5	2,689	6.5
Lambton Hospitals					
2003/04	15,133	11,938	78.9	3,195	21.1
2004/05	15,408	11,938	77.5	3,470	22.5
2005/06	16,485	12,501	75.8	3,984	24.2
ESC LHIN Hospitals					
2003/04	64,704	56,520	87.4	8,184	12.6
2004/05	66,308	57,189	86.2	9,119	13.8
2005/06	71,305	61,495	86.2	9,810	13.8

Source: PHPDB NACRS Database September 2006

Observations

- ESC LHIN residents accounted for over 71,000 day surgery procedures in all Ontario hospitals, 61,495 or 86% of which occurred in ESC LHIN hospitals (2005/06)
- Approximately 24% of both Chatham-Kent and Lambton residents had day surgery procedures performed in out-of-county hospitals, while only 6.5% of Essex residents sought treatment outside Essex County

Day Surgery Procedures for ESC LHIN Residents by Hospital Location 2005/06

Hospital Location	Chatham-Kent Residents		Essex Residents		Lambton Residents		ESC LHIN Residents	
	#	%	#	%	#	%	#	%
Chatham-Kent	10,114	76.3	315	0.8	488	3.0	10,917	15.3
Essex	1,111	8.4	38,880	93.5	480	2.9	40,471	56.8
Lambton	422	3.2	**	**	12,501	75.8	12,923	18.1
London	1,284	9.7	1,835	4.4	1,656	10.1	4,775	6.7
Other Middlesex	147	1.1	**	**	817	5.0	964	1.4
Toronto	67	0.5	310	0.8	102	0.6	479	0.7
Perth	**	**	**	**	223	1.4	223	0.3
All other	106	0.8	229	0.5	218	1.3	553	0.8
Total	**13,251**		**41,569**		**16,485**		**71,305**	

Source: PHPDB NACRS Database September 2006

**Numbers suppressed due to small cell count

Observations

- *Of the 24% of Chatham Kent residents who have day surgery procedures performed outside Chatham Kent, almost 10% were performed in London hospitals, over 8% in Essex hospitals, 3% in Lambton and 1% in Middlesex hospitals*
- *Only 6.5% of Essex residents had day surgery procedures performed outside of Essex, with the majority (4.4%) performed in London hospitals*
- *For the 24% of Lambton residents having day surgery procedures outside of Lambton, 10% were performed in London hospitals, 5% in other Middlesex hospitals, 3% in each of Essex and Chatham Kent and slightly over 1% in Perth hospitals*

2.5 Priority Programs and Services

Definition

- Age standardized knee replacements/100,000 population
- Wait times in ESC LHIN compared to Ontario
- Age standardized hip replacements/100,000 population
- Wait times in ESC LHIN compared to Ontario

- Age and Sex Adjusted Cataract surgery/100,000 population
- Ranking by LHIN
- Wait times in ESC LHIN compared to Ontario
- Number, age and sex adjusted rate of specific cancer surgeries/100,000 pop
- Median wait times in ESC LHIN compared to Ontario
- Number, age and sex adjusted rate of inpatient and outpatient CT and MRI scans/100,000 Pop, ESC LHIN and Ontario
- Wait times in ESC LHIN compared to Ontario
- Cardiac procedures
- Median wait times ESC LHIN and Ontario 2004/05
- Angiography
- Bypass surgery
- Angioplasty
- Trends in 2005/06 for wait times, ESC LHIN

Significance/Uses

- Identifies patterns of utilization of the MOHLTC's priority programs. Provincial and Federal governments identified reduced wait times and improved access for these procedures as key priorities
- Demand for these procedures is expected to increase with population aging
- Long waits for these procedures is associated with substantial pain and/or disability
- Indicator of current capacity
- Identifies patterns of inflow/outflow of patients for procedures

Limitations

- Separations may include multiple admissions for an individual
- Excludes inpatient cataract surgery procedures
- In 2002/03 coding of procedures changed from the Canadian Classification of Diagnostic, Therapeutic and Surgical Procedures (CCP) to the Canadian Classification of Health Interventions (CCI) based on ICD 10 CA coding. CCI is much more detailed than CCP so changes over time should be interpreted with caution

Source

- CIHI Health Indicator Reports 2004/05, MOHLTC website – Wait Times in Ontario, August 2006, ICES Access to Health Services in Ontario, 2nd Edition May 2006

Age Standardized Knee Replacements per 100,000 Population 2004/05

	Rate/100,000	Inflow/Outflow Ratio
Chatham-Kent	138.9	0.73
Essex	114.9	0.95
Lambton	106.6	1.04
ESC LHIN	117.4	0.92
Ontario	107.0	N/A

Source: CIHI Health Indicator Reports 2004/05 data

- significantly higher than the provincial rate based on assessment of 95% confidence intervals

Observations

- The rate per 100,000 population for knee replacements in ESC is higher than that of Ontario (117.4 compared to 107.0)
- The rate in Chatham Kent is significantly higher than that of the province at almost 139
- Overall in ESC LHIN, there is a higher proportion of ESC LHIN residents going outside the ESC LHIN for knee replacement than non-residents coming into the LHIN for this procedure. The exception is Lambton County which has a higher inflow of patients. These findings are probably indicative of the availability of orthopaedic services within the individual communities

Wait Times (in days) for Knee Replacement Surgery in ESC LHIN and Ontario for Selected Time Periods 2005/2006

		Aug – Sep 05	*Oct – Nov 05*	*Dec 05 – Jan 06*	*Feb – Mar 06*	*Apr – May 06*	*June – July 06*
Median	Ontario	147	150	122	123	146	113
	ESC LHIN	112	127	118	143	161	141
90%	*Target*	*182*					
	Ontario	440	431	422	395	408	388
	ESC LHIN	288	351	307	386	422	392

Source: MOHLTC website September 2006.

Observations

- In February/March and April/May 2006, ESC LHIN median wait times increased significantly and have remained above the provincial median since that time. The provincial median decreased significantly for June/July
- The length of time in which 90% of the knee replacements are completed remains higher than Ontario
- Both the Ontario and ESC LHIN 90% wait times far exceed the provincial target

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Age Standardized Hip Replacement per 100,000 Population 2004/05

	Rate/100,000	Inflow/Outflow Ratio
Chatham-Kent	102.9	0.74
Essex	71.9	0.96
Lambton	80.6	1.06
ESC LHIN	79.7	0.93
Ontario	107.0	N/A

Source: CIHI Health Indicator Reports 2004/05 data

- Significantly lower than the provincial rate based on the assessment of 95% confidence intervals

Observations

- The rate of hip replacement surgery per 100,000 population is significantly lower than that of the province. This is true for all areas of ESC with the exception of Chatham Kent. The rate for Chatham Kent is also below that of the province, but this difference is not considered to be statistically significant in the assessment of 95% confidence intervals

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Wait Times (in days) for Hip Replacement Surgery in ESC LHIN and Ontario for Selected Time Periods 2005/06

		Aug – Sep 05	Oct – Nov 05	Dec 05 – Jan 06	Feb – Mar 06	Apr – May 06	June – July 06
Median	Ontario	119	106	96	97	99	85
	ESC LHIN	125	110	103	99	113	98
90%	*Target*	*182*					
	Ontario	351	341	331	336	329	288
	ESC LHIN	234	231	211	211	245	232

Source: MOHLTC website, September 2006

Observations

- Wait times for hip replacement surgery across ESC LHIN decreased to previous levels in June/July 2006 but median wait times remain above that of the province
- 90% of the hip replacement surgeries are performed in a considerably shorter period of time than the province, however the waiting time is still below the provincial target

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Number, age and sex adjusted rate of Cataract Surgery per 100,000 Population aged 20 years and older by LHIN of residence and Ontario 2002/03 – 2004/05

	2002/03		2003/04		2004/05	
	# Cataract Surgeries	Rate per 100,000	# Cataract Surgeries	Rate per 100,000	# Cataract Surgeries	Rate per 100,000
ESC LHIN	6,474	1,287	6,706	1,316	7,288	1,417
Ontario	99,102	1,102	102,644	1,116	111,194	1,185

Source: ICES, Access to Health Services in Ontario: 2nd Edition, May 2006

Observations

- The number of cataract surgeries continued to increase in Ontario as well as in ESC from 2002/03 to 2004/05
- The age and sex adjusted rate per 100,000 population was considerably higher in ESC than in Ontario for all three years

Age and sex adjusted rate of Cataract Surgery per 100,000 Population aged 20 years and older by LHIN and Ontario 2004/05

Local Health integration Network	Rate per 100,000
ESC	1,417
South West	1,271
Waterloo Wellington	1,020
Hamilton Niagara Haldimand Brant	1,152
Central West	919
Mississauga Halton	1,121
Toronto Central	901
Central	1,133
Central East	1,264
South East	1,261
Champlain	1,368
North Simcoe Muskoka	1,276
North East	1,368
North West	1,193
All Ontario	**1,185**

Source: ICES, Access to Health Services in Ontario, 2nd Edition: Chapter 4, Cataract Surgery

Observations

- ESC LHIN had the highest age and sex adjusted rate in the province
- ESC rate was 1.6 times higher than the lowest rate (901 procedures per 100,000 population) in the Toronto Central LHIN

Wait Times (in days) for Cataract Surgery ESC LHIN and Ontario for Selected Time Periods 2005/06

		Aug – Sep 05	Oct – Nov 05	Dec 05 – Jan 06	Feb – Mar 06	Apr – May 06	June – July 06
Median	Ontario	99	93	78	78	76	68
	ESC LHIN	36	25	31	30	37	34
90%	*Target*	*182*					
	Ontario	311	314	297	291	277	250
	ESC LHIN	160	185	93	128	124	79

Source: MOHLTC website September 2006

Observations

- The median cataract wait times in ESC are much lower than the province, ranging from 25 to 37 days for the time periods shown
- 90% of all cataract surgeries in ESC are done well within the target of 182, for all but one of the time periods shown. They are done in about half the provincial wait time

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Number and Age and Sex-Adjusted Rate of Specific Cancer Surgeries per 100,000 population aged 40 years and older in ESC LHIN and Ontario 2002/03 – 2004/05

Large Bowel Resection for Cancer

	2002/03		2003/04		2004/05	
	# cases	Rate per 100,000	# cases	Rate per 100,000	# cases	Rate per 100,000
ESC LHIN	342	114	357	117	351	113
Ontario	6,018	111	6,134	110	6,210	109

Mastectomy for Cancer

	2002/03		2003/04		2004/05	
	# cases	Rate per 100,000	# cases	Rate per 100,000	# cases	Rate per 100,000
ESC LHIN	172	112	189	121	181	115
Ontario	2,721	96	2,651	91	2,672	90

Radical Prostatectomy for Cancer

	2002/03		2003/04		2004/05	
	# cases	Rate per 100,000	# cases	Rate per 100,000	# cases	Rate per 100,000
ESC LHIN	118	83	99	69	160	110
Ontario	2,636	101	2,612	98	2,809	103

Hysterectomy for Cancer

	2002/03		2003/04		2004/05	
	# cases	Rate per 100,000	# cases	Rate per 100,000	# cases	Rate per 100,000
ESC LHIN	106	69	103	67	91	57
Ontario	1,792	63	1,793	62	1,865	63

Source: ICES, Access to Health Services in Ontario, 2nd Edition, May 2006

Observations

- Large bowel resection surgery rates appear similar to Ontario rates
- Mastectomy rates appear to be higher than Ontario rates
- Prostatectomy rates show considerable year to year variation
- There appears to be a reduction in the rates for hysterectomy over the three-year period

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Median Wait Times (Days), 90% Completed within (days) –Selected Cancer Procedures, 2004/05

	Bowel Resection		Mastectomy		Radical Prostatectomy		Hysterectomy	
	Median Wait Time (Days)	90% Completed Within (Days)	Median Wait Time (Days)	90% Completed Within (Days)	Median Wait Time (Days)	90% Completed Within (Days)	Median Wait Time (Days)	90% Completed Within (Days)
ESC LHIN	27	84	25	92	102	164	47	111
Ontario	29	85	29	86	93	155	43	113

Source: ICES, Access to Health Services, 2nd Edition

Observations

- ESC LHIN median wait times are slightly less than the province for large bowel resection and mastectomy, but longer for radical prostatectomy and slightly longer for hysterectomy
- 90% of large bowel resections and hysterectomies are completed in a similar timeframe to Ontario, while prostatectomies and mastectomies are slightly longer
- Although not shown, the percentage of surgeries completed within six weeks is very similar to that for the province with the proportion of mastectomies 10% higher than the province within this timeframe:
  - Large bowel resection – 67%, same as Ontario
  - Mastectomy – 75%, compared with 65% for Ontario
  - Radical prostatectomy – 16%, compared with 13% for Ontario
  - Hysterectomy 47%, compared with 48% for Ontario

Radiation Therapy Median Time from Referral to Treatment*
March to May 2006

Cancer Type	London Regional Cancer Centre	Windsor Regional Cancer Centre	Unweighted Average of Medians	Ratio to Ontario Average of Medians: London Regional Cancer Centre	Ratio to Ontario Average of Medians: Windsor Regional Cancer Centre
Breast	8.0	6.0	6.5	1.23	0.92
Central Nervous System	**	2.7	3.9		0.70
Gastro-Intestinal	2.9	**	3.5	0.82	
Genitourinary Cancer	7.7	13.4	7.7	1.00	1.75
Gynecologic	6.9	3.5	6.8	1.01	0.51
Haematology	1.1	3.7	4.9	0.22	0.75
Head and Neck	4.5	2.3	5.1	0.89	0.45
Lung	2.1	3.9	2.6	0.80	1.49
Sarcoma	5.7	**	6.7	0.85	

*Cancer Care Ontario website, Aug. 2006

**Numbers surpressed due to small cell count

Systemic Therapy Median Time from Referral to Treatment*
March to May 2006

Cancer Type	London Regional Cancer Centre	Windsor Regional Cancer Centre	Unweighted Average of Medians	Ratio to Ontario Average of Medians: London Regional Cancer Centre	Ratio to Ontario Average of Medians: Windsor Regional Cancer Centre
Breast	5.5	3.8	4.7	1.17	0.81
Central Nervous System	**	**	4.2		
Gastro-Intestinal	5.7	3.7	5.2	1.09	
Genitourinary Cancer	4.9	1.6	4.7	1.04	0.34
Gynecologic	5.6	1.9	4.4	1.27	0.43
Haematology	3.8	4.1	4.4	0.87	0.94
Head and Neck	2.7	**	4.1	0.66	
Lung	4.0	4.3	4.4	0.91	0.98
Sarcoma	3.8	**	6.0	0.63	

*Cancer Care Ontario website, Aug. 2006

**Numbers surpressed due to small cell count

Observations

- There are some therapies that are not provided in Windsor, requiring patients to travel outside ESC for care
- Windsor RCC wait times for radiation and systemic therapy are generally lower than Ontario wait times

Number and Age and Sex-Adjusted Rate of Inpatient and Outpatient CT Scans per 100,000 Population, ESC LHIN and Ontario 2002/03 - 2004/05

	2002/03		2003/04		2004/05	
	# of CT scans	Rate per 100,000	# of CT scans	Rate per 100,000	# of CT scans	Rate per 100,000
ESC LHIN	50,110	7,692	55,735	8,432	61,712	9,223
Ontario	951,540	7,863	1,035,653	8,375	1,180,413	9,354

Source: ICES, Access to Health Services in Ontario, 2nd Edition, May 2006

Number and Age and Sex-Adjusted Rate of Inpatient and Outpatient MRI Scans per 100,000 Population, ESC LHIN and Ontario

2002/03 - 2004/05

	2002/03		2003/04		2004/05	
	# of MRI scans	Rate per 100,000	# of MRI scans	Rate per 100,000	# of MRI scans	Rate per 100,000
ESC LHIN	8,113	1,266	9,030	1,395	10,001	1,530
Ontario	183,966	1,520	207,188	1,680	257,042	2,047

Source: ICES, Access to Health Services in Ontario, 2nd Edition, May 2006

Observations

- The number of CT and MRI scans has continued to increase in Erie St. Clair as in Ontario overall
- In 2004/05 the rate of CT scanning was five times higher than the rate of MRI scans in Ontario, and approximately six times higher in Erie St. Clair
- The age and sex adjusted rate of CT scans for Erie St. Clair is slightly below that of Ontario, and ranks number seven of 14 LHINs
- The age and sex adjusted rate of MRI scans for Erie St. Clair is well below that of the province, and in fact is the lowest rate in the province

Wait Times (in days) for CT Scanning, Erie St. Clair LHIN and Ontario for Selected Time Periods in 2005/06

		Aug – Sep 05	Oct – Nov 05	Dec 05 – Jan 06	Feb – Mar 06	Apr – May 06	June – July 06
Median	Ontario	13	14	14	13	13	13
	ESC LHIN	7	25	27	8	14	19
90%	*Target*	*28*					
	Ontario	81	79	74	69	71	70
	ESC LHIN	112	102	84	85	97	73

Source: MOHLTC website September 2006

Wait Times (in days) for MRI Scanning, Erie St. Clair LHIN and Ontario for Selected Time Periods in 2005/06

		Aug – Sep 05	Oct – Nov 05	Dec 05 – Jan 06	Feb – Mar 06	Apr – May 06	June – July 06
Median	Ontario	32	27	32	28	31	36
	ESC LHIN	8	23	31	41	43	37
90%	*Target*	*28*					
	Ontario	120	110	105	88	91	92
	ESC LHIN	26	96	71	61	78	67

Source: MOHLTC website September 2006

Observations

- The median wait time for CT scans in Erie St. Clair has fluctuated over the time periods shown (from 7 to 27 days), but increased in April/May and June/July 2006 and for June/July is six days longer than the province
- The period of time in which 90% of scans are completed increased in February/March and April/May 2006, but decreased in June/July and was very close to the provincial average. Both are far below the target rate

Median Wait Times, 90% Completed and Percentage of Coronary Angiographies Performed within Recommended Maximum Wait Times (RMWT), by Urgency Category, ESC LHIN and Ontario 2004/05

	Urgent (RMWT 0-7			Semi-Urgent (RMWT 8-28 days)			Elective (RMWT 29 days or >)		
	Median Wait Times (Days)	90% Completed within (Days)	% Completed within RMWT	Median Wait Times (Days)	90% Completed within (Days)	% Completed within RMWT	Median Wait Times (Days)	90% Completed within (Days)	% Completed within RMWT
ESC LHIN	3	10	61	15	57	41	27	67	59
Ontario	1	6	71	11	52	49	21	62	70

Source: ICES Atlas, Access to Health Services Ontario, 2nd Edition, May

Comments: Since Ontario wait times have not been adopted for coronary angiography, the Cardiac Care Network of Ontario's Urgency Rating System was used.

Observations

- It is noted in the above reference publication that wait times for coronary angiography varied considerably across Local Health Integration Networks and within urgency groups
- Median wait times for coronary angiography in Erie St. Clair was higher than the province in all categories
- In Erie St. Clair, for urgent cases, the median wait time was three days compared to one for Ontario. Although not shown here, other LHIN wait times varied between one and two days, with ESC the longest at three days
- The number of days in which 90% of cases were completed was longer than the province in all categories for ESC LHIN
- The percentage of cases completed within the Recommended Maximum Wait Times in Erie St. Clair for urgent cases was 10% less than Ontario, for semi urgent cases was 8% less than Ontario, and for elective cases 11% less than Ontario

Median Wait Times, 90% Completed and Percentage of Bypass Surgery Performed Within Ontario Wait Time Targets, by Urgency Category, ESC LHIN and Ontario Residents 2004/05

	Urgent (Target 2 weeks)			Semi-Urgent (Target 6 weeks)			Elective (Target 26 weeks)		
	Median Wait Time (Days)	90% Completed within (Days)	% Performed within target	Median Wait Time (Days)	90% Completed within (Days)	% Performed within target	Median Wait Time (Days)	90% Completed within (Days)	% Performed within target
ESC LHIN	4	8	67	8	41	81	23	97	79
Ontario	3	11	72	7	41	83	24	75	86

Observations

- For urgent cases, the median wait time in Erie St. Clair was one day longer than Ontario, but 90% of cases were performed within eight days compared with 11 for the province. 67% of bypass surgeries for urgent cases were performed within the two week Ontario target, compared with 72% for the province
- For semi urgent cases, the median wait time again was one day longer than the province, 90% of cases were completed in 41 days, the same as the province, and 81% of cases were completed within the Ontario target of six weeks
- For elective cases, the median wait time was one day less than the province, while 90% of elective bypass cases were completed within 97 days compared with 75 for Ontario, and 79% of cases were performed within the Ontario target of 26 weeks (compared with 86% of the province)

Median Wait Times and 90% of Angioplasties Completed, by Patient Location at Time of Referral, ESC LHIN and Ontario 2004/05

	Referral from Home		Referred from In-Hospital		Overall	
	Median Wait Time (Days)	90% Completed within (Days)	Median Wait Time (Days)	90% Completed within (Days)	Median Wait Time (Days)	90% Completed within (Days)
ESC LHIN	18	48	3	8	7	30
Ontario	17	55	1	5	3	30

Source: ICES Atlas, Access to Health Services Ontario, 2nd Edition, May 2006

Comments: There are currently no Ontario Recommended Maximum Wait Times for angioplasty

Observations

- Median wait times for Erie St. Clair residents for angioplasty were longer than that of the province for both out patient and in hospital referrals and more than twice as long as the province
- For in hospital referrals, the median wait time for Erie St. Clair LHIN residents was second highest in the province, second only to the North West LHIN median wait time of six days
- 90% of Erie St. Clair residents' angioplasties were completed within 30 days, the same as the provincial average

Trends in 2005/06 for Cardiac Surgery Wait Times, ESC LHIN and Ontario

Angiography

	Aug-Sep 2005		Oct-Nov 2005		Dec 05-Jan 06		Feb-Mar 2006		Apr-May 2006		June-July 2006	
	Median Wait Time (Days)	90% Comp Within (Days)	Median Wait Time (Days)	90% Comp Within (Days)	Median Wait Time (Days)	90% Comp Within (Days)	Median Wait Time (Days)	90% Comp Within (Days)	Median Wait Time (Days)	90% Comp Within (Days)	Median Wait Time (Days)	90% Comp Within (Days)
ESC LHIN	27	58	22	35	19	52	11	16	22	38	3	28
Ontario	15	56	14	38	14	38	13	33	13	31	12	28

Source: MOHLTC website September 2006

Observations

- The median wait times for angiography in Ontario continue on a decreasing trend to 12 days in the most recent time periods available
- The median wait times in Erie St. Clair decreased to a low of three days in June July
- The number of days in which 90% of angiographies are completed has decreased to 28 which is the provincial average

Angioplasty

	Aug-Sep 2005		Oct-Nov 2005		Dec 05-Jan 06		Feb-Mar 2006		Apr-May 2006		June-July 2006	
	Median Wait Time (Days)	90% Completed Within (Days)	Median Wait Time (Days)	90% Completed Within (Days)	Median Wait Time (Days)	90% Completed Within (Days)	Median Wait Time (Days)	90% Completed Within (Days)	Median Wait Time (Days)	90% Completed Within (Days)	Median Wait Time (Days)	90% Completed Within (Days)
South West*	4	41	4	34	[illegible]	30	3	[illegible]	3	[illegible]	3	31
Ontario	5	28	5	[illegible]	[illegible]	[illegible]	4	31	4	30	4	31

Bypass Surgery

	Aug-Sep 2005		Oct-Nov 2005		Dec 05-Jan 06		Feb-Mar 2006		Apr-May 2006		June-July 2006	
	Median Wait Time (Days)	90% Completed Within (Days)	Median Wait Time (Days)	90% Completed Within (Days)	Median Wait Time (Days)	90% Completed Within (Days)	Median Wait Time (Days)	90% Completed Within (Days)	Median Wait Time (Days)	90% Completed Within (Days)	Median Wait Time (Days)	90% Completed Within (Days)
South West*	22	54	19	50	15	50	21	49	27	50	23	42
Ontario	14	49	13	42	14	45	13	41	15	48	13	39

Source: MOHLTC website August 2006

Comment: Angioplasty and Bypass surgery not performed in ESC LHIN, so South West LHIN data are provided.

Observations

- Median wait times in SW LHIN for June/July 2006 were one day below that of Ontario, although the period of time in which 90% of procedures were completed is 10 days longer than the province
- For bypass surgery, medium wait time in SW LHIN is five days greater than the Ontario and length of time in which 90% of procedures are done is nine days greater

2.6 Acute Care Utilization by Level of Care

Definition

- Separations from ESC LHIN acute hospitals by level of care and by patient residence
- Separations by ESC LHIN residents from acute hospitals by level of care and hospital location
- Level of Care categories are based on the 2002/03 Hay Group Methodology used by Joint Policy & Planning Committee (JPPC) to group cases according to the degree of medical specialization required and the age of the patient

The levels are:

- Primary – medical care provided by general practitioners or specialists that can be provided in any hospital
- Secondary – includes surgical procedures and services provided by medical specialists
- Tertiary/Quaternary – specialized services provided to seriously ill patients in a small number of hospitals, which serve as regional referral centres.

Significance/Uses

- Serves as an indicator of types and complexity of care provided
- Indicator of system capacity
- Level of care reflects the relative resource intensity or cost of care provided
- Level of care is dependent on physician availability
- Reflects changes occurring in the delivery of health care services

Limitations

- Age standardized separation rates are only available at the ESC LHIN level
- The MOHLTC is reevaluating the assignment of hospital care complexity given the inconsistency in coding of the "case complexity" code used in previous versions of the Hay Group methodology. The case complexity code has been removed from the 2002/03 methodology. This indicator should be considered a descriptive

measure rather than a definitive measure of the complexity of care provided. For more information on the Hay Group methodology and Level of Care see: www.jppc.org

- Updated CMGs based on ICD 10 CA and CCI are not yet available. With the changes in coding, the assignment of CMGs is more difficult. There have been changes in the volumes by CMG since the change in coding; therefore trends must be interpreted with caution. For more information on the coding change see: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=casemix_ICDimpact03_e
- Level of care is based on CMG and age categories and may not reflect the actual complexity of the case

Source

- Acute Care Utilization Report, Health System Intelligence Project 2006.

Total Separations by Level of Care by ESC LHIN Hospitals 2004/2005

	Primary		Secondary		Tertiary/Quaternary		Total
	#	%	#	%	#	%	#
Chatham-Kent	4,859	53.6	4,019	44.3	189	2.1	9,067
Essex	14,681	44.2	16,038	48.3	2,508	7.5	33,227
Lambton	5,393	51.3	4,706	44.8	413	3.9	10,512
ESC LHIN	24,933	47.2	24,763	46.9	3,110	5.9	52,806
Ontario	459,234	45.8	435,297	43.4	107,802	10.8	1,002,333

Source: Acute Care Utilization Report, Health System Intelligence Project March 2006

Observations in ESC LHIN Hospitals

- 94% of separations were primary or secondary
- 6% of separations were tertiary/quaternary
- Compared with Ontario hospitals, ESC LHIN hospitals had larger proportions of primary and secondary separations and a smaller proportion of tertiary/quaternary separations
- The figures reflect services available
- Chatham Kent had the highest proportion of primary separations across the ESC LHIN – almost 54%, and the lowest proportion of tertiary/quaternary separations – 2%
- Lambton's primary and secondary cases were similar in proportion to Chatham Kent, with a slightly higher proportion of tertiary/quaternary cases at 4%
- Essex hospitals had a lower proportion of primary cases and slightly higher proportion of secondary cases than Ontario, with 7.5% tertiary/quaternary cases compared with almost 11% province wide

Total Separations by Level of Care, ESC Residents by Area of Residence 2004/2005

	Primary		Secondary		Tertiary/Quaternary		Total
	#	%	#	%	#	%	#
Chatham-Kent	5,332	45.8	5,281	45.4	1,025	8.8	11,638
Essex	14,663	41.6	16,780	47.6	3,839	10.9	35,282
Lambton	6,392	47.0	6,029	44.4	1,173	8.6	13,594
ESC LHIN	26,387	43.6	28,090	46.4	6,037	10.0	60,514
Ontario	455,262	45.9	430,779	43.4	105,910	10.7	991,951

Source: Acute Care Utilization Report, Health System Intelligence Project, March 2006

Observations

- 90% of ESC residents' hospital separations were primary or secondary and 10% were tertiary/quaternary, similar to the province, although it is noted that there was a higher proportion of secondary separations than the province.

Although not shown in the above data, information from the above referenced report states that:

- ESC Hospitals served [illegible]% of ESC residents' primary, [illegible]% of secondary and [illegible]% of tertiary/quaternary separations.
- South West LHIN hospitals provided care to [illegible]% of ESC residents' tertiary/quaternary separations, while hospitals in the Toronto Central LHIN provided care to [illegible]% of residents.
- Chatham-Kent residents' hospital separations were evenly split between primary and secondary, with approximately 9% tertiary/quaternary, slightly below the provincial average.
- Essex residents had a higher percentage of secondary separations than primary and similar percentage of tertiary/quaternary (11%) to the province.
- Lambton residents had a slightly higher proportion of primary separations than secondary and slightly lower percentage of tertiary/quaternary separations than the province - similar to Chatham-Kent at approximately 9%.

Age Standardized Separation Rates per 1,000 Population by Level of Care, ESC LHIN and Ontario Residents 2004/2005

Level of Care	ESC Residents	Ontario Residents
Primary	40.3	36.7
Secondary	39.9	32.4
Tertiary/Quaternary	8.4	7.9
Total Separations	**88.5**	**77.0**

Source: Acute Care Utilization Report, Health System Intelligence Project, March 2006

- Significantly different from provincial average based on assessment of 95% confidence intervals

Observations

- Age standardized separation rate for all levels of care is significantly higher than for Ontario residents

2.7 Acute Inpatient Mental Health Utilization

Definition

- Number of acute inpatient psychiatric separations, patient days and average (total) length of stay (ALOS) for hospitals in the ESC LHIN
- Number of acute inpatient mental health separations, patient days and ALOS by ESC LHIN residents from Ontario hospitals per 1000 area resident population

Significance/Uses

- Indicator of the level of acute inpatient mental health care provided within community hospitals to an area resident population
- Useful for monitoring the progress of mental health reform
- Comparisons over time and place

Limitations

- Statistics are based on patients with a mental health program cluster category treatment of some of these patients (eating disorders, psychogeriatric patients etc) may occur within medical beds
- Captures utilization patterns not population need
- To make fair comparisons between and within districts, adjustments for age, sex, disease complexity and length of stay are required
- Lack of physician and community resources may affect use of hospital services
- Does not include separations from the tertiary care mental health hospitals
- Separations may include multiple admissions for an individual

Source

- Acute Care Utilization Report, Health System Intelligence Project, March 2006

Selection Criteria

- All mental health cases treated in Ontario hospitals (PCC 20), Ontario totals exclude out of province residents

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Mental Health Separations, Days, & Average Length of Stay (ALOS), ESC LHIN & Ontario Hospitals, 2004/05

Facility Location	Acute Separations	Total Days	Total ALOS	Acute Days	Acute ALOS
Chatham-Kent	566	7,870	13.9	7,127	12.6
Essex	2,633	29,923	11.4	29,188	11.1
Lambton	850	10,036	11.8	8,191	9.6
ESC LHIN	4,049	47,829	11.8	44,506	11.0
Ontario	57,683	696,049	12.1	621,495	10.8

Source: Acute Care Utilization Report, Health System Intelligence Project, March 2006

Note: This table shows the total number of mental health separations in ESC hospitals, based on the Psychiatry Program Cluster Category. Some of these cases will be treated in beds other than designated psychiatric beds. Provincial numbers do not include hospitalizations in specialized mental health facilities (former provincial psychiatric hospitals). Acute ALOS represents the average length of stay excluding Alternate Level of Care (ALC) days, while Total ALOS includes ALC days. As noted elsewhere in this report, ALC days are likely under reported.

Observations

ESC Hospitals

- Acute mental health separations represented 7.7% of all separations and 15.4% of total days from ESC hospitals, higher proportions than those for Ontario hospitals (5.8% and 10.9% respectively)
- These numbers accounted for 7% of mental health separations and 6.9% of mental health days from Ontario hospitals
- In ESC, the total ALOS was almost one day longer than the acute ALOS, which reflects the impact of ALC stays

- Overall, the total ALOS for ESC hospitals (11.8 days) was slightly shorter than the total ALOS in Ontario hospitals (12.1)
- 99% of mental health separations from ESC hospitals were by ESC residents, with South West LHIN (0.5%) and out of province (0.2%) the next most common areas of patient origin for mental health separations from ESC hospitals

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Acute Mental Health Separations, Days, & Average Length of Stay (ALOS), by Area of Residence, ESC LHIN & Ontario Residents, 2004/05

Patient Residence	Acute Separations	Total Days	Total ALOS	Acute Days	Acute ALOS
Chatham-Kent	586	8,173	13.9	7,451	12.7
Essex	2,595	29,892	11.5	29,150	11.2
Lambton	911	10,539	11.6	8,754	9.6
ESC LHIN	4,092	48,604	11.9	45,355	11.1
Ontario	57,282	692,244	12.1	617,970	10.8

Source: Acute Care Utilization Report, Health System Intelligence Project, March 2006

ESC Residents

- Acute mental health separations represented 6.8% of all separations and 13.7% of total days for ESC residents, higher than the corresponding proportions for Ontario residents (5.8% ad 10.9% respectively)
- ESC residents accounted for 7.1% of the mental health separations and 7.0% of the total mental health days for Ontario residents
- For ESC residents, the total ALOS was almost one day longer than the acute ALOS which reflects the impact of ALC stays
- The total ALOS for mental health for ESC residents was 11.9 days, slightly less than the total ALOS for Ontario residents (12.1 days)

Overall

- 97.5% of mental health separations for residents of ESC were from ESC hospitals
- 2.1% of mental health separations for residents of ESC were from the South West LHIN
- 0.4% of mental health separations for residents of ESC were from other LHINs
- Average length of stay patterns for ESC residents were similar to that for ESC LHIN hospitals

Age-Standardized Acute Mental Health Separation Rates per 1,000 Population & Crude Total Mental Health Day Rates per 1,000 Population, ESC LHIN & Ontario Residents, 2004/05

	ESC Residents	Ontario Residents
Age Standardized Separation Rate	6.1	4.5
Crude Total Day Rate	75.3	55.9

Source: Acute Care Utilization Report, Health System Intelligence Project, March 2006

- Significantly different from provincial average based on assessment of 95% confidence intervals

Observations

- The age-standardized acute mental health separation rate for ESC residents was significantly higher than the rate for Ontario residents
- The crude total mental health day rate was approximately 35% higher than the rate for Ontario residents

2.8 Regional Care Inpatient Psychiatric Utilization

Definition

- Inpatient psychiatry separations, days and ALOS for ESC LHIN residents treated in Regional Mental Health Care London and St. Thomas

Significance/Uses

- Indicator of regional inpatient mental health utilization among area residents
- Provides an indicator of the size of the "hard to treat" psychiatric population
- Useful in planning local treatment programs for the seriously mentally ill population
- Provides information on the characteristics of patients and patterns of use of the tertiary care facilities
- Useful for monitoring the progress of mental health reform

Limitations

- Captures utilization patterns, not population needs
- This indicator is limited to utilization of Regional Mental Health Care London/St. Thomas, and does not include other Ontario facilities

Source

- Regional Mental Health Care, London and St. Thomas, August 2006

Number of Separations, Total Days and Average Length of Stay (ALOS)
ESC LHIN Residents, 2005/06

	# Separations	Discharge Days	ALOS
Chatham-Kent	30	4,973	166
Essex	32	10,429	326
Lambton	72	8,618	120
ESC LHIN	134	24,020	179

Discharge Destination of ESC LHIN Residents from
Regional Mental Health Care 2005/06

Responsible Agent of Discharge	**Chatham-Kent**	**Essex**	**Lambton**	**ESC LHIN**
	# cases	**# cases**	**# cases**	**# cases**
Self/Family	19	20	22	61
General Hospital, Non-psychiatric	1	0	2	3
Psychiatric Outpatient Facility	2	2	17	21
Psychiatric Inpatient Facility	2	1	1	4
Nursing Home	1	1	8	10
Homes for Special Care	0	0	1	1
Doctor/Therapist	1	1	10	12
Forensic	1	1	3	5
Community Non-institution No Beds	0	0	0	0
Community Institution Other	0	0	0	0
Other	3	6	8	17
TOTAL	**30**	**32**	**72**	**134**

Discharge Separation Type ESC Residents, Regional Mental Health Care 2005/06

	Chatham-Kent	Essex	Lambton	ESC LHIN
Discharge Separation Type	# cases	# cases	# cases	# cases
Regular discharged	26	28	65	119
Discharged while on LOA	2	2	6	10
Discharged Against Medical Advice	0	0	0	0
Discharged while AWOL	0	0	0	0
Death while an Inpatient	0	1	1	2
Death while on LOA	0	0	0	0
Transfer out	2	1	0	3
Total	**30**	**32**	**72**	**134**

First Admissions vs. Readmission as a Percentage of Total Admissions to Regional Mental Health Care, ESC Residents 2005/06

	First Admission (%)	**Readmission (%)**	**Total Admissions**
Chatham-Kent	45.2	54.8	31
Essex	48.6	51.4	35
Lambton	58.9	41.1	73
ESC LHIN	53.2	46.7	139

Admissions by Referral Source to Regional Mental Health Care, ESC Residents 2005/06

Referral Source on Admission	Chatham-Kent # cases	Essex # cases	Lambton # cases	ESC LHIN # cases
General Hospital Emergency Dept.	3	4	3	10
Psychiatric Outpatient Facility	5	3	12	20
Psychiatric Inpatient Facility	14	17	35	66
General Hospital Non-Psychiatric	2	4	3	9
Medical/Therapist	0	3	11	14
Self/Family	1	0	4	5
Forensic	3	2	0	5
Nursing Home	0	0	5	5
Community Non-institution No Beds	3	0	0	3
Community Institution Other	0	1	0	1
Homes for Special Care	0	0	0	0
Other	0	1	0	1
Total	**31**	**35**	**73**	**139**

Admission Legal Status as a Percentage of Total Admissions to Regional Mental Health Care, ESC Residents 2005/06

Admission Legal Status	Voluntary %	Involuntary %	Forensic %	A.P.A.* %
Chatham-Kent	64.5	16.1	12.9	6.5
Essex	62.9	22.9	11.4	2.9
Lambton	63.0	24.7	8.2	4.1
ESC LHIN	63.3	22.3	10.1	4.3

*Application for Psychiatric Assessment

Observations

- Although there were only 134 ESC LHIN residents discharged from London St Thomas tertiary psychiatric facilities, their total days under care were over 24,000 (69 beds at 95% occupancy)
- 46% of the patients were discharged to home
- 16% were discharged to a psychiatric OP service
- 13% were discharged to a nursing home
- Half were readmissions
- The most common referral source was an inpatient psychiatric facility (48%)

2.9 Utilization of Complex Continuing Care

Definition

- Average beds staffed and in operation for ESC LHIN Complex Continuing Care units 2005/04 – 2005/06
- RUGS weighted patient days for ESC LHIN and Ontario hospitals 2005/06

Significance/Uses

- Reflects the capacity and activity of the existing hospital system

Limitations

- Limited data on CCC utilization is presented in this report due to resource limitations. Efforts will be made to provide more comprehensive information in future reports

Source

- FIM website, HIT series, PDST

Trending of Average Beds Staffed and in Operation and Total Patient Days, ESC LHIN Hospitals 2003/04 – 2005/06

	2003/04		2004/05		2005/06	
Planning Area	Average Beds Staffed and In Operation	Total Patient Days	Average Beds Staffed and In Operation	Total Patient Days	Average Beds Staffed and In Operation	Total Patient Days
Chatham-Kent	44	14,906	46	17,732	51	22,019
Essex	102	35,553	107	39,589	122	52,120
Lambton	83	28,552	83	28,655	83	29,269
ESC LHIN	229	79,011	236	85,976	256	103,408

Source: MOHLTC FIM website, HIT series Patient Days, PDST average beds staffed and in operation 2003/04 2004/05, MOHLTC FIM Daily Census Reports 2005/06 beds staffed and in operation.

Observations

- There continues to be an upward trend in the number of patient days for Complex Continuing Care patients across the ESC LHIN, as evidenced by the increasing number of beds from 229 in 2003/04 to 256 for 2005/06
- The bed numbers and patient days have remained stable in Lambton over the period
- Bed numbers have increased in Chatham-Kent over the period, from 44 in 2003/04 to 51 in 2005/06 and patient days have increased by 48% over the same period
- Bed numbers have increased in Essex by 20 over the three year period with a corresponding increase in patient days of 47%

RUGS-Weighted Patient Days, ESC LHIN and Ontario Hospitals 2005/06

	RUGS Weighted Patient Days	Percent Provided in ESC LHIN
Chatham-Kent	21,979	22%
Essex	49,422	51%
Lambton	26,776	27%
ESC LHIN	98,177	100%
Ontario	1,953,270	
ESC LHIN as a % of Ontario		5%

Source: MOHLTC FIM website, HIT series August 2006

Observations

- Essex County hospitals account for 51% of the ESC LHIN weighted patient days, with 27% provided by Lambton and 22% by Chatham Kent
- It is noted that overall, ESC Hospital patients represent 5% of total RUGS weighted patient days in the province
- The average Case Mix Index (CMI) in ESC LHIN for 2005/06 is 0.95 and although not represented here, it is noted that the average CMI has been on a downward trend (1.08 in 2003/04, 1.05 in 2004/05 and 0.95 in 2005/06). The average CMI for Ontario is not available at this time

2.10 Utilization of Rehabilitation Services

Definition

- Separations, discharge days of separation and average lengths of stay from designated inpatient rehabilitation units in ESC LHIN hospitals
- Change in functional score as measured at admission and discharge from inpatient rehabilitation units

Significance/Uses

- Reflects the capacity and activity of the inpatient rehabilitation hospital system
- Reflects the improvement of functional status in rehabilitation units
- Provides information on where patients were admitted from and discharged to

Limitations

- Not all patients requiring rehabilitation are admitted to the units
- There are issues with the completeness and consistency of coding for Functional Status
- Data does not represent the types of cases, complexity or age specificity. This information may be helpful for planning purposes in future reports
- Data on inpatient rehabilitation in the PHPDB is only available up to the end of September, 2005 at the time of writing

Source

- PHPDB MOHLTC FIM website, HIT series, August 2006, PDST, PHPDB Inpatient Rehab.

Rehabilitation Inpatient Days, ESC LHIN Hospitals 2003/04 - 2005/06

Planning Area	Hospital	2003/04	2004/05	2005/06*
Chatham-Kent	Chatham Kent Health Alliance	**7,787**	**7,782**	**7,291**
Essex	Leamington District Memorial Hospital	2,270	2,093	2,200
	Hotel-Dieu Grace Hospital	4,707	4,381	4,554
	Windsor Regional Hospital	16,488	16,692	17,261
Essex Total		**23,465**	**23,166**	**24,015**
Lambton	Bluewater Health	**9,198**	**9,329**	**9,274**
ESC LHIN		40,450	40,277	40,580
Ontario		715,199	760,892	N/A

Source: PDST 2003/04 - 2004/05,

*2005/06 data from MOHLTC FIM website, HIT series, August 2006

Observations

- ESC hospitals account for approximately 5% of the total rehabilitation days in Ontario
- The number of inpatient rehabilitation days in ESC has remained relatively constant over the past three years, with Chatham-Kent showing a slight decline, Essex a slight increase and Lambton remaining approximately the same. This is a bed-limited service with generally high occupancy

Average Number of Beds Staffed and Operational, Number of Separations, Inpatient Days and Average Length of Stay, ESC Hospital Rehabilitation Units, 2004/05

Planning Area	Average Number of Beds Staffed and Operational	Number of Separations	Patient Days	Average Length of Stay
Chatham-Kent	22	309	7,782	25.2
Essex	79	1,614	23,166	14.4
LDMH	6	203	2,093	10.3
HDGH	24	884	4,381	5
WRH	49	527	16,692	31.7
Lambton	27	353	9,329	26.4
ESC LHIN	128	2,276	40,277	17.7
Ontario	2,373	32,001	760,892	23.8

Source: PDST website July 2006

Observations

- The average length of stay for rehabilitation patients in the ESC LHIN is shorter than that for Ontario hospitals (17.7 compared with 23.8) although there is wide variation in lengths of stay across the hospitals in the ESC LHIN. This is likely reflective of the different types of patients served, different levels of service provided, etc. therefore average lengths of stay should not be viewed in isolation of other factors

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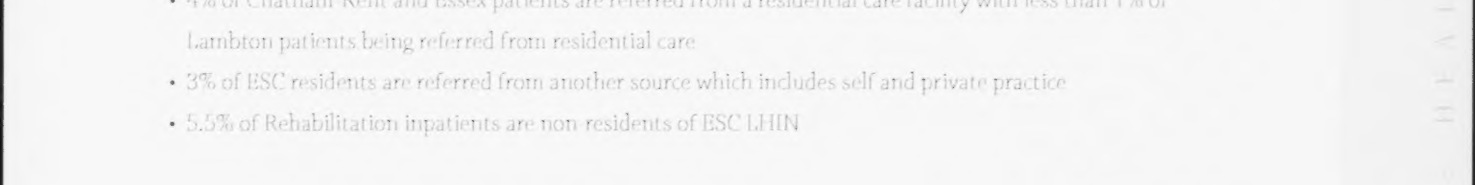
Referral Source as a Percent of Total Rehabilitation Inpatients, 2004/05

	In-Patient Facility	Residential Care Facility	Rehab Unit in Another Facility	Other
Chatham-Kent	95%	4%		1%
Essex	85%	4%	8%	3%
Lambton	97%			3%
ESC LHIN	88%	3%	6%	3%

Source: PHPDB, MOHLTC September 2006

Observations

- The majority of rehabilitation patients are referred from an acute inpatient facility – 95% of Chatham-Kent patients, 97% of Lambton patients and 85% of Essex patients
- 8% of Essex rehab patients are referred from a rehabilitation unit in another facility
- 4% of Chatham-Kent and Essex patients are referred from a residential care facility with less than 1% of Lambton patients being referred from residential care
- 3% of ESC residents are referred from another source which includes self and private practice
- 5.5% of Rehabilitation inpatients are non-residents of ESC LHIN



Referral Destination for Rehabilitation Inpatients as a Percent of Total Separations, 2004/05

	Home Care	Residential Care Facility	Ambulatory Care	Other Rehab Facility	Other	Not Indicated
Chatham-Kent	49%	28%			6%	17%
Essex	28%	11%	11%	7%	8%	35%
Lambton	36%	12%	27%		7%	18%
ESC LHIN	32%	14%	12%	5%	7%	30%

Source: PHPDB, MOHLTC September 2006

Observations

- Approximately one-third of all rehabilitation separations do not indicate a referral source. It is assumed that a large proportion of these were discharged home
- A higher percentage of Chatham-Kent patients were referred to Home Care (49% compared to 28% for Essex, and 36% for Lambton)
- A larger proportion of Chatham-Kent patients were referred to residential care facilities (28%)
- A higher percentage of Lambton patients were referred to ambulatory care facilities compared to 11% of Essex patients and less than 1% of Chatham-Kent patients

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Average Total Function Change for Inpatient Rehabilitation, ESC LHIN Hospitals

Planning Area	Hospital	Average Change in Total Function Score 2004/05	Average Change in Total Function Score 2005/06*(6 Months)
Chatham-Kent	Chatham-Kent Health Alliance	20.13	19.95
Essex	Leamington District Memorial Hospital	17.07	16.09
	Hotel-Dieu Grace Hospital	19.26	20.86
	Windsor Regional Hospital	17.64	16.46
Lambton	Bluewater Health	19.52	20.38

Source: PHPDB, MOHLTC September 2006

2005/06 based on available data at time of printing, April – September 2005

Observations

- The average change in Total Function score has remained constant in 2004/5 and the first half of 2005/6

2.11 Alternate Level of Care (ALC)

Definition

- Trend of % ALC days of total days ESC LHIN and Ontario Hospitals
- Bed equivalents at 85% occupancy 2005/06
- Comparison of Ontario LHINs 2004/05 and 2005/06
- Program cluster categories and transfer locations for ALC patients 2004/05
- An ALC patient is a non-acute patient occupying an acute care bed while awaiting placement in a CCC unit, home for the aged, nursing home, rehabilitation facility, other extended care institution or home care program etc. The patient is classified as ALC when the physician issues an order to change the level of care and requests a transfer to another program

Significance/Uses:

- HSRC directives called for the elimination of ALC days in acute care hospitals
- May reflect the inefficient use of acute care hospital beds or lack of access to LTC, rehabilitation and/or community services
- Institution types to which ALC patients are transferred and program cluster categories may identify access barriers leading to ALC days
- ALC days can be converted to beds unavailable for acute care use by dividing by 365 and factoring at 85% occupancy rate

Limitations

- There is considerable variability in the reporting of ALC cases. Differences may reflect reporting policies rather than true differences in access, therefore the numbers should be interpreted with caution. Changes in policy may account for some of the changes that have appeared
- Despite implementation of rigorous discharge protocols, ALC cases may be under-reported because there is no incentive to do so
- Previous versions of this indicator excluded patients in the psychiatry and neonatal program cluster categories. However, since psychiatry has been identified as an area where access to resources such as tertiary beds may be lacking this version includes ALC days from all program cluster categories

Source

- Health Information Portal, MOHLTC, Posted August 2006

Trend of Percentage of Alternate Level of Care (ALC) Days of Total Days 2003/04 – 2005/06 for ESC LHIN and Ontario Hospitals

	2003/2004			2004/2005			2005/2006			
	ALC Days	Total Days	% ALC Days	ALC Days	Total Days	% ALC Days	ALC Days	Total Days	% ALC Days	Bed Equiv at 85% Occ*
Chatham-Kent	3,866	55,585	7.0%	3,838	52,878	7.3%	3,416	51499	6.6%	11
Essex	7,849	196,604	4.0%	8,028	193,154	4.2%	12,532	199,960	6.3%	40
Lambton	2,043	64,346	3.2%	4,927	64,124	7.7%	8507	62,932	13.5%	27
ESC LHIN	13,758	316,535	4.3%	16,793	310,156	5.4%	24,455	314,391	7.8%	78
Ontario	584,213	7,271,768	8.0%	567,548	7,169,275	7.9%	591,123	8,104,407	7.3%	1905

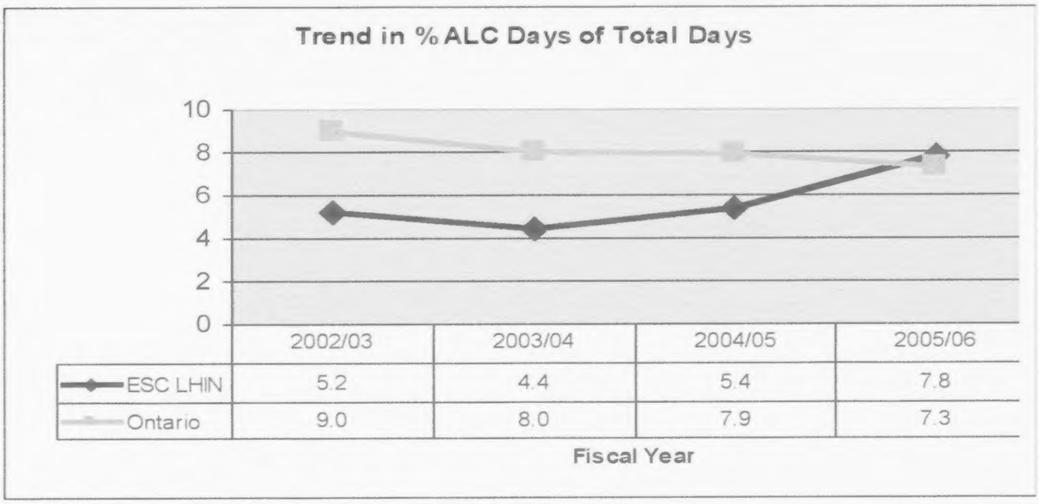
Source: Health Information Portal, MOHLTC, Posted August 2006

*Bed equivalents at 85% occupancy

ESC LHIN Observations

- Over the last three fiscal years, the total number of ALC days in ESC has increased by 78% (from 13,758 to 24,455)
- % ALC days of total days in ESC LHIN has increased from 4.3% in 2003/04 (well below the provincial rate) to 7.8% in 2005/06 (slightly above the provincial rate)
- The dramatic increase in 2005/2006 is in part attributed to data collection improvement initiatives by the hospitals within the ESC LHIN
- There are 78 beds not available for acute care because they are used for ALC days
- Chatham-Kent is the only area within the ESC LHIN where the number of ALC days has decreased over the three year period. This may be reflective of additional CCC beds being placed into the system over the past year
- Although the % ALC days in Essex County remain slightly below the provincial average, the rate increased 2% over the previous year
- Lambton had the greatest increase in ALC days across the ESC LHIN, from 4.3% in 2003/04 to 13.5% in 2005/06. This increase has been due in part to improved data collection initiatives and education of staff regarding the importance of appropriate ALC designation

Trend in Percentage of ALC Days ESC LHIN and Ontario 2002/03 – 2005/06



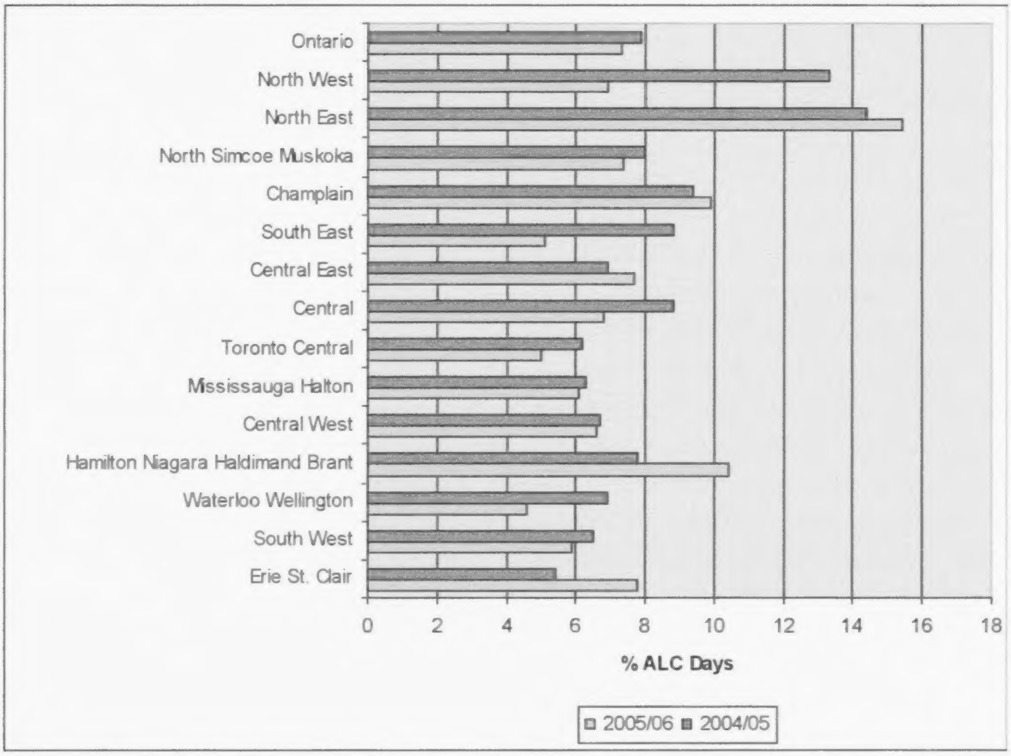
	2002/03	2003/04	2004/05	2005/06
ESC LHIN	5.2	4.4	5.4	7.8
Ontario	9.0	8.0	7.9	7.3

Source: Health Information Portal, MOHLTC, Posted August 2006

Observations

- While there has been a downward trend in % ALC days in Ontario hospitals, the ESC hospitals have been trending upward after a brief decline in 2003/2004. ESC hospitals now have a higher percentage of ALC days than the province
- There have been ongoing initiatives in ESC hospitals over the past two years to improve the appropriate capture of ALC data, and this is reflected in the increasing numbers. (It had been identified by those involved in the capture of the data that the ALC numbers had been being under-reported in the past, hence the initiatives to improve the data capture). Since this is one of the 23 indicators in the Local Health System Scorecard, ALC days will continue to be monitored on an ongoing basis within the ESC LHIN

Alternate Level of Care Days by LHIN of Institution, Ontario and 14 LHINS 2004/05 vs. 2005/06



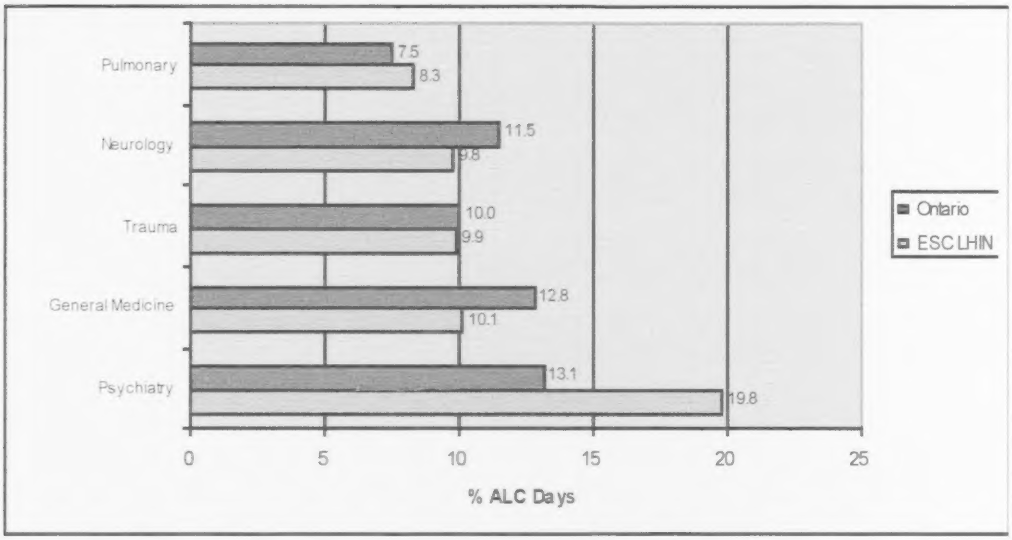
Source: Health Information Portal, MOHLTC, Posted August 2006

Observations

- The graph shows that ESC LHIN which was ranked first among all 14 LHINs in 2004/05 for the lowest % of ALC days is now ranked 11th out of 14 LHINs, with the 4th highest % of ALC days
- ESC LHIN is now slightly higher than Ontario for % ALC days
- While the numbers in 2004/05 were felt to be under-reported, further monitoring will need to be done to determine if the 2005/06 numbers are an accurate reflection of the ALC issue in ESC

Program Cluster Categories and Transfer Locations for 2005/06 were not prepared for this report, but the following information is provided for 2004/05 ALC cases and will be updated to monitor ongoing trends.

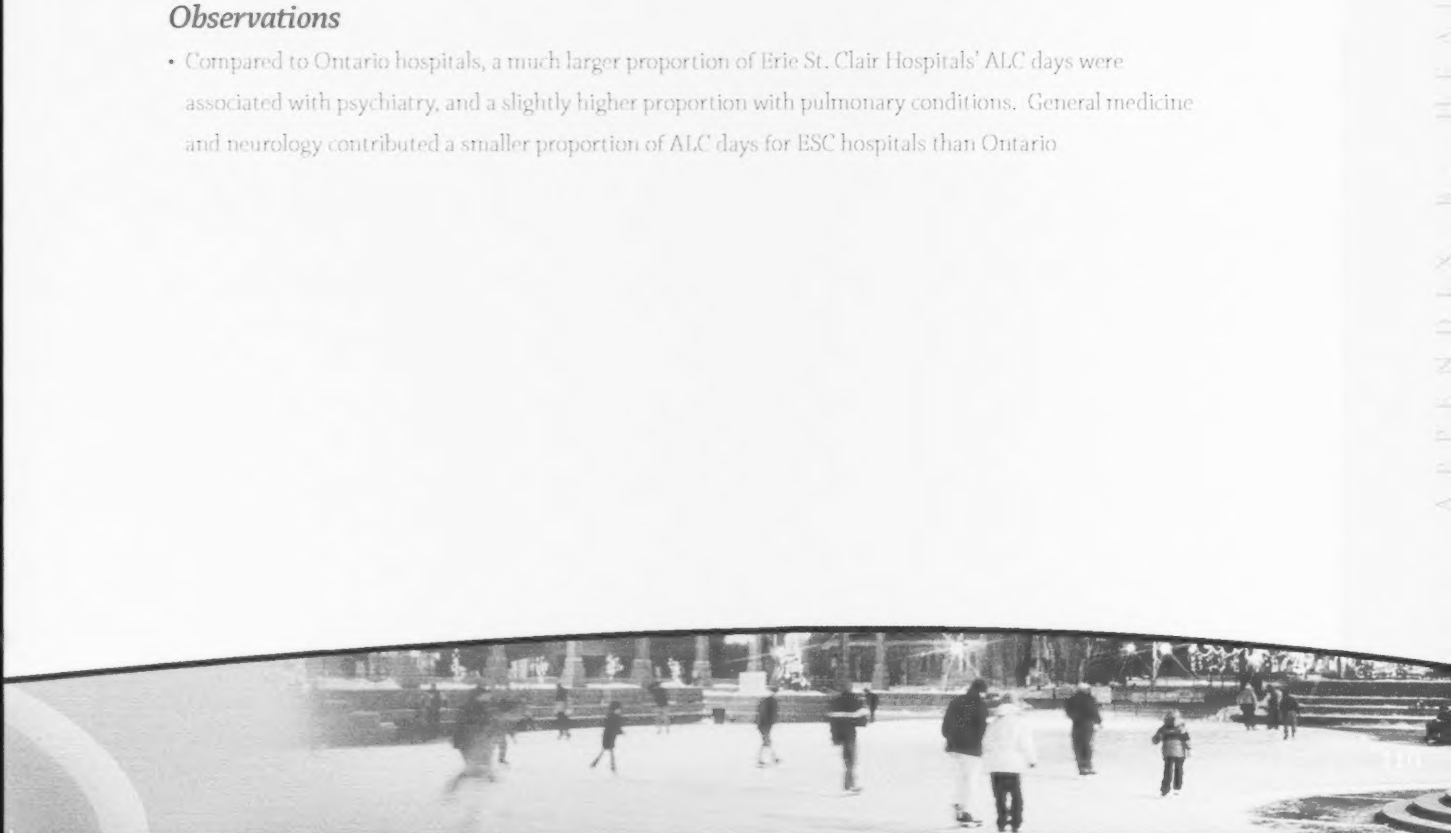
Top 5 Program Cluster Categories (PCCs) as a Proportion of ALC Days, Erie St. Clair and Ontario Hospitals 2004/2005



Source: Acute Care Utilization Report, Health System Intelligence Project, March 2006

Observations

- Compared to Ontario hospitals, a much larger proportion of Erie St. Clair Hospitals' ALC days were associated with psychiatry, and a slightly higher proportion with pulmonary conditions. General medicine and neurology contributed a smaller proportion of ALC days for ESC hospitals than Ontario



Alternate Level of Care (ALC) Separations, Days & Average Length of Stay (ALOS) for Specific Transfer Locations, Erie St. Clair & Ontario Hospitals, 2004/2005

Transfer Locations	Erie St. Clair Hospitals			Ontario Hospitals		
	Separations	Days	ALOS	Separations	Days	ALOS
Long Term Care Home	473	4,970	10.5	8,579	197,545	23.0
No transfer/unknown	454	4,069	9.0	8,722	124,164	14.2
Complex Continuing Care	454	3,451	7.6	8,428	105,506	12.5
General Rehabilitation	207	1,222	5.9	6,358	57,179	9.0
Home Care	183	1,200	6.6	4,320	48,628	11.3
Special Rehabilitation	98	703	7.2	825	8,593	10.4
Acute Care Facility	69	468	6.8	1,080	12,660	11.7
Psychiatric Facility	18	543	30.2	130	3,108	23.9
Unclassified/Other facility	17	160	9.4	582	9,741	16.7
Ambulatory Care/Outpatient Dept.	--	--	--	28	424	15.1
TOTAL	**1975**	**16,793**	**8.5**	**39,052**	**567,548**	**14.5**

Source: Acute Care Utilization Report, Health System Intelligence Project, March 2006

-- Cell count suppressed due to small numbers (<5 separations)

Observations

- The transfer destinations associated with the highest volume of cases and days were: Long Term Care Homes, No transfer/unknown location (home, death, etc.) and Complex Continuing Care facilities
- Although less than 1% of ALC patients were transferred to psychiatric facilities, these transfers were associated with the longest ALC ALOS for both Erie St. Clair (30.2 days) and Ontario (23.9 days)
- The ALC ALOS in Erie St. Clair was shortest for General Rehabilitation (5.9 days), followed by Home Care (6.6 days) and Acute Care (6.8 days)
- Compared to Ontario hospitals the ALC ALOS for Erie St. Clair was shorter for transfers to all locations except psychiatric facilities

2.12 Waiting Lists for Long Term Care Homes

Definition

- Number of people on waiting lists for Long Term Care (LTC) Homes (nursing homes and homes for the aged)
- Number of people admitted to LTC Homes

Significance/Uses

- The Community Care Access Centres (CCAC) coordinate placement and maintain centralized waiting lists for all LTC homes. These waiting lists have been in place since 1997
- Eligible individuals from anywhere in Ontario can be placed on any home's waiting list
- Factors affecting waiting lists include: availability of funding, health care personnel, equipment, beds and specialized services
- Provides information on accessibility and availability of services
- Provides information on supply-demand mismatch and can help health services planning

Limitations

- Waiting lists may be inflated with people on the list who do not immediately require services or who are awaiting placement in their preferred facility while already residing in a LTC facility
- People may be on more than one waiting list
- Waiting lists are subject to agency policies

Source

- Community Care Access Centres (CCAC) - Windsor-Essex, Chatham-Kent and Sarnia-Lambton, MOHLTC LTCPR Client Profile Database (CPRO), posted August 2006, Health Information Portal

Number of Clients Waiting for Placement and Placed Per Month by County and ESC LHIN – 2005/06

	Chatham-Kent		Essex		Lambton		ESC LHIN	
Month	Waiting	Admitted	Waiting	Admitted	Waiting	Admitted	Waiting	Admitted
April	99	42	641	94	224	39	964	175
May	90	41	697	77	229	39	1,016	157
June	85	41	755	81	234	51	1,074	173
July	96	31	804	72	251	37	1,247	140
August	105	32	839	81	257	36	1,201	149
September	107	26	891	65	271	39	1,269	130
October	111	43	909	58	276	50	1,296	151
November	96	34	917	59	273	39	1,286	132
December	92	28	943	75	267	50	1,302	153
January	98	42	955	64	281	60	1,334	166
February	97	34	976	62	262	39	1,335	135
March	101	39	970	80	265	57	1,336	176
Average /Month	**98**	**36**	**858**	**72**	**258**	**45**	**1,222**	**153**

Source: Chatham Kent CCAC, Sarnia Lambton CCAC, Windsor-Essex CCAC

The table above represents the total number of clients waiting and admitted to Long Term Care beds per month for fiscal 2005/06. The "waiting" column includes those who are already in a nursing home bed awaiting a bed of their first choice.

Observations

- On average, in 2005/06 there were 1,222 clients waiting for Long Term Care placement across ESC, although it is recognized that this number is somewhat elevated by the fact that it includes clients who are already in a LTC bed that is not their first choice and therefore stay on the waiting list until their first choice bed becomes available
- Although the systems are not in place in all the CCACs to enable us to determine how many clients on an ongoing basis are in a LTC bed awaiting further placement, a snapshot in time as in the table below shows that for one month, approximately 42% of the clients were already in a LTC bed. In future, efforts will be made to track this number across all the CCACs on an ongoing basis

- An average of 153 clients are placed on a monthly basis, or approximately 13%
- The ratio of patients placed/waiting is worst in Essex, with only 8% of those waiting being placed on a monthly basis
- 17% of Lambton clients who are waiting are placed monthly
- 37% of Chatham Kent clients waiting are placed monthly

Number of People Waiting For and Admitted to LTC Homes in November 2005 by Place of Waiting by County

	Community		LTC Facility		Hospital		Out of County		Total	
	Waiting	Admitted	Waiting	Admitted	Waiting	Admitted	Waiting	Admitted	Waiting	Admitted
Chatham-Kent	35	15	29	3	26	15	6	1	96	34
Essex	361	22	391	19	138	17	18	0	908*	58*
Lambton	103	18	121	1	40	16	9	4	273	39
ESC LHIN	499	55	541	23	204	48	33	5	1277	131

Source: Chatham-Kent CCAC, Sarnia Lambton CCAC, Windsor Essex CCAC

*Unable to reconcile to previous table

The table above represents a snapshot in time for the month of November 2005, of those waiting for and admitted to Long Term Care homes by place of waiting. It should be noted that the systems currently in place do not allow for easy tracking of these numbers and therefore numbers should be used with caution and not in isolation.

Observations

- In the month of November 2005, 131 clients across ESC were admitted to LTC facilities
- Approximately 42% were admitted from the community, 17% from other LTC facilities, 37% from hospitals and 4% from out of county

Trend of Median Time to Placement (Days) to LTC Facilities by LHIN and Ontario 2003/04 – 2005/06

(i) All Placements:*

	2003/04		2004/05		2005/06	
LHIN	Placements	Median TTP	Placements	Median TTP	Placements	Median TTP
ESC LHIN	**1,504**	**17**	**1,301**	**20**	**1,100**	**32**
South West	2,188	39	1,983	45	2,037	52
Waterloo Wellington	1,238	60	1,226	47	1,108	53
Hamilton Niagara Haldimand Brant	2,729	64	2,883	30	2,448	34
Central West	696	40	1,198	22	1,122	18
Mississauga Halton	1,265	39	1,202	24	1,151	23
Toronto Central	1,131	42	1,599	23	1,394	28
Central	1,835	48	1,893	34	2,103	26
Central East	2,633	34	3,114	30	2,651	29
South East	891	67	1,007	80	982	90
Champlain	1,285	79	1,124	76	1,957	85
North Simcoe Muskoka	753	102	822	70	760	58
North East	1,271	62	1,297	56	945	65
North West	372	242	515	81	450	102
Ontario	**19,791**	**N/A**	**21,164**	**N/A**	**20,211**	**N/A**

Source: MOHLTC Client Profile Database (CPRO) posted August 2006, Health Information Portal

*All placements include clients placed from hospitals (acute, rehab, CCC), supportive housing, retirement homes, home, other. Excludes clients placed from LTC homes. Clients whose "Admitted from" and/or "prior location code" is unknown are excluded.

(ii) Placements from Community

	2003/04		2004/05		2005/06	
LHIN	**Placements**	**Median TTP**	**Placements**	**Median TTP**	**Placements**	**Median TTP**
ESC LHIN	**671**	**41**	**560**	**42**	**432**	**56**
South West	930	65	851	66	889	87
Waterloo Wellington	629	107	639	81	572	113
Hamilton Niagara Haldimand Brant	1,106	132	1,152	59	836	65
Central West	338	75	515	44	421	34
Mississauga Halton	544	76	460	44	412	47
Toronto Central	471	126	584	75	508	71
Central	1,101	84	1,005	62	1,041	56
Central East	1,279	53	1,311	56	913	70
South East	499	88	564	116	533	130
Champlain	678	111	573	112	1,017	134
North Simcoe Muskoka	363	188	436	133	399	127
North East	477	89	532	74	413	86
North West	99	274	141	288	155	287
Ontario	**9,185**	**86**	**9,323**	**68**	**8,541**	**79**

Source: MOHLTC LTCPR Client Profile Database (CPRO), Posted August 2006, Health Information Portal

*(iii) Placements from Acute Care***

	2003/04		2004/05		2005/06	
LHIN	Placements	Median TTP	Placements	Median TTP	Placements	Median TTP
ESC LHIN	**659**	**9**	**588**	**10**	**496**	**17**
South West	937	24	817	31	814	28
Waterloo Wellington	475	27	422	19	391	20
Hamilton Niagara Haldimand Brant	1,188	31	1,276	12	1,244	16
Central West	281	18	517	14	454	12
Mississauga Halton	463	19	477	14	459	14
Toronto Central	552	17	762	10	668	14
Central	623	18	759	14	865	13
Central East	1,006	19	1,276	16	1,181	18
South East	288	51	307	42	311	48
Champlain	466	43	435	45	651	29
North Simcoe Muskoka	277	30	304	20	264	20
North East	662	46	631	37	410	52
North West	91	80	259	48	198	43
Ontario	**7,968**	**24**	**8,830**	**18**	**8,406**	**19**

Source: MOHLTC LTCPR Client Profile Database (CPRO), posted August 2005, Health Information Portal

**Includes patients from acute care hospitals only (excludes rehab, CCC)

The three previous tables represent trends of median time to placement in days to Long Term Care homes from 2003/04 to 2005/06. The analysis is based on all placements received (not all placements CCAC were reported). Time to placement is calculated as the time from the earlier of LTC Home Application Date or Consent Date to date of placement.

Observations

- *Median time to placement across the ESC LHIN has increased from 2003/04 to 2005/06, for all placements, as well as placements from acute care and from community*
- *ESC LHIN ranked 6th out of 14 LHINs for the shortest median TTP in 2005/06*
- *ESC LHIN ranked 3rd in median TTP from the community for 2005/06 and 4th in median TTP from acute care both these median times were lower than Ontario*

2.13 Community Care Utilization

2.13.1 CCAC Utilization

Definition

- *Number of clients, units and average service units per CCAC client by type of home care service and per 1000 area resident population of a given area*
- Number of clients and units of service for community support services, by type of service
- Number of clients and units of service for Children's Treatment Centres by type of service

Community Care Access Centres (CCACs) are responsible for provision of information and referral services, placement coordination and case management and are also responsible for the indirect delivery (through contracts) of professional services (nursing, therapies etc) for individuals living in the community.
Community Support Services are non-professional services provided to individuals in the community in their own homes or in other places in the community. They include transportation, meals-on-wheels, adult day services etc, provided by non-profit and for-profit community agencies.
Children's Treatment Centres (CTCs) are community agencies which provide treatment and support services for children with physical disabilities.

Significance/Uses

- *With the move from institutionalization and shorter hospital stays, more people are receiving care in the community*
- *Indicator of the various types of in-home services that measures level of support care an area resident population is receiving*

Limitations

- Indicator does not capture provision of informal and family support
- CCACs and other agencies may use different definitions for units of service so differences should be interpreted with caution
- There have been numerous program changes and changes in service definitions
- Additional community support programs are available which are not captured here because they are not funded by MOHLTC
- *Community Support Service and CTC service estimates are based on budgeted figures which may not reflect actual service levels for that year*

Source

- *Individual Community Care Access Centres (CCACs) from PMI dataset, MOHLTCPIM website August 2006.*

CCAC Utilization by Planning Area, 2005/6*

	0-18		19-64		65+		All Ages	
Planning Area**	Visits	Costs	Visits	Costs	Visits	Costs	Visits	Costs
Chatham-Kent	10,121	$ 734,756	65,634	$ 2,843,975	194,553	$ 6,520,060	270,308	$ 10,098,791
Essex	58,011	$ 3,204,133	230,583	$ 9,538,704	603,443	$ 20,324,890	892,037	$ 33,067,728
Lambton	13,046	$ 840,357	80,117	$ 3,460,236	242,667	$ 7,061,203	335,830	$ 11,351,796
ESC LHIN	81,178	$ 4,779,246	376,334	$ 15,832,915	1,040,663	$ 33,906,153	1,498,175	$ 54,518,314

*Direct Service Costs only, net overhead

**excluding services identified as provided to non-ESC LHIN clients (11 visits)

CCAC Utilization by Service, 2005/6*

	0-18		19-64		65+		All Ages	
Service Type	Visits	Costs	Visits	Costs	Visits	Costs	Visits	Costs
Homemaker	16,354	$ 601,472	160,791	$ 4,312,756	416,020	$ 10,243,907	593,165	$ 15,158,136
Nursing	37,360	$ 1,754,803	197,830	$ 10,076,731	147,187	$ 7,399,433	382,377	$ 19,230,968
Dietician	61	$ 6,003	1,079	$ 115,649	117,375	$ 5,911,217	118,515	$ 6,032,869
Occupational Therapy	10,954	$ 930,368	3,790	$ 314,917	5,423	$ 517,922	20,167	$ 1,763,207
Physiotherapy	2,468	$ 220,448	9,833	$ 741,620	337,610	$ 8,585,348	349,911	$ 9,547,416
Speech Pathology	13,957	$ 1,263,891	1,015	$ 82,939	13,512	$ 966,265	28,484	$ 2,313,094
Social Work	16	$ 1,780	1,444	$ 156,838	2,313	$ 200,670	3,773	$ 359,288
Enterostomal Therapy	8	$ 480	552	$ 31,464	1,223	$ 81,392	1,783	$ 113,336
Combined	81,178	$ 4,779,246	376,334	$ 15,832,915	1,040,663	$ 33,906,153	1,498,175	$ 54,518,314

CCAC Utilization by Service, 2005/6*

as percent spent in each age group

	0-18		19-64		65+		All Ages	
Service Type	**Visits**	**Costs**	**Visits**	**Costs**	**Visits**	**Costs**	**Visits**	**Costs**
Homemaker	20%	13%	43%	27%	40%	30%	40%	28%
Nursing	46%	37%	53%	64%	14%	22%	26%	35%
Dietician	0%	0%	0%	1%	11%	17%	8%	11%
Occupational Therapy	13%	19%	1%	2%	1%	2%	1%	3%
Physiotherapy	3%	5%	3%	5%	32%	25%	23%	18%
Speech Pathology	17%	26%	0%	1%	1%	3%	2%	4%
Social Work	0%	0%	0%	1%	0%	1%	0%	1%
Enterostomal Therapy	0%	0%	0%	0%	0%	0%	0%	0%
Combined	100%	100%	100%	100%	100%	100%	100%	100%

CCAC Service Utilization Rates/1,000, 2005/6*

	0-18		19-64		65+		All Ages	
Planning Area	**Visits**	**Costs**	**Visits**	**Costs**	**Visits**	**Costs**	**Visits**	**Costs**
Chatham-Kent	387	$ 28,078	988	$ 42,791	11,720	$ 392,775	2,475	$ 92,454
Essex	590	$ 32,580	902	$ 37,297	11,891	$ 400,490	2,203	$ 81,679
Lambton	435	$ 28,044	986	$ 42,483	11,490	$ 334,337	2,538	$ 85,803
ESC LHIN	525	$ 30,937	933	$ 39,246	11,763	$ 383,250	2,318	$ 84,344

Ratio to ESC LHIN

	0-18		19-64		65+		All Ages	
Planning Area	**Visits**	**Costs**	**Visits**	**Costs**	**Visits**	**Costs**	**Visits**	**Costs**
Chatham-Kent	0.74	0.91	1.06	1.09	1.00	1.02	1.07	1.10
Essex	1.12	1.05	0.97	0.95	1.01	1.04	0.95	0.97
Lambton	0.83	0.91	1.06	1.08	0.98	0.87	1.10	1.02
ESC LHIN	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00

Observations

- Almost $55M was spent on CCAC direct care in 2005/6 to deliver 1.5M visits
- 600,000 visits were made by homemakers (Personal Support Workers), followed by 382,000 by nurses and 350,000 visits provided by physiotherapists
- Enterostomal therapy was identified as being provided only in Essex
- Children (0-18) receive primarily nursing, speech pathology, homemaker and Occupational Therapy services
- Adults (19-64) receive primarily (and almost evenly split) homemaking and nursing
- Elderly (65+) receive 40% homemaking, nursing and Physiotherapy services
- Dietician services account for 8% of all services provided
- All other services are 2% or less
- In 2005/6 direct service provision cost 10 times as much per capita for persons 65+ than it did for persons 19-64
- The cost per capita for 0-18 and 19-64 was roughly the same, although the rates of services provided were very different

2.13.2 Community Support Services

Definition

- Community Support Services includes some 57 different services/agencies that receive funding to support persons to live in individual or small group settings. The range is very broad, including adult day services for frail persons, to meals on wheels, foot care and home making for persons with acquired brain injury living in supportive housing units. Limited service and budget information is provided in this report

Significance/Uses

- Many of these services are part of the critical linkages that keep people out of institutions

Limitations

- It is very difficult to develop efficiency measures from these services because they provide very different types of services and/or work in very different communities
- Data collection by very small agencies poses considerable challenges. Gathering additional information may be very difficult

Source

- MOHLTCFIM website August 2006 "Community Support Services Summary Reports", corporate report form MOHLTC FIM-IMU

Community Support Services Programs, 2005/6

Funded in ESC LHIN

	Planning Area				
Service	Chatham-Kent	Essex	Lambton	ESC LHIN	Ontario
Adult Day Service (Alzheimers/Other Aging Dementia)	1	1	2	4	58
Adult Day Service (Frail Elderly)	0	0	2	2	25
Adult Day Service-Integrated-Frail/Alzheimers/Other Dementia	1	2	1	4	103
Adult Day Service	1	1	0	2	11
Alzheimers/Dementia Overnight Service	0	0	1	1	9
Meals on Wheels	5	6	2	13	161
Diners Club/Wheels to Meals/Congregate Dining	0	1	1	2	164
Transportation	2	7	2	11	183
Home Maintenance and Repair (Brokerage)	0	1	2	3	88
Friendly Visiting	1	3	1	5	152
Security Checks/Reassurance Service	1	5	1	7	120
Caregiver Support - Support and Counselling	2	2	0	4	61
Caregiver Support - Training, Information and Education	2	1	1	4	63
Caregiver Support (Paid Staff)	1	1	1	3	47
Caregiver Support - Volunteer Hospice Visiting Service	1	1	1	3	77
Caregiver Support (Volunteer)	0	0	2	2	18
Extended Respite Service	0	0	1	1	5
Home Help/Homemaking (Paid)	0	0	1	1	64
Public Education Coordinator	1	1	1	3	40
Psychogeriatric Consulting Services (Alzheimer Strategy)	0	1	0	1	23
Foot Care	1	3	0	4	45
Client Intervention and Assistance Service (Seniors)	0	0	1	1	59
Geriatric Assessment Program - Windsor	0	1	0	1	2
Homemaking/Personal Supp/Attendant - Elderly in SHU	1	1	0	2	104
Supportive Living Service - Physically Disabled Adults	1	1	1	3	65
Homemaking/Personal Supp/Attendant/Respite-Phys Dis Outreach	1	1	1	3	46
Supportive Living Service - ABI in SHU	0	1	0	1	19
Case Management	1	0	1	2	16
Special Services For the Blind and Visually Impaired	0	1	0	1	21
Special Services For Persons with Acquired Hearing Loss	0	1	0	1	14
Non LTC Pay Equity	5	7	2	14	78
Total Funded Programs	29	51	29	109	2,373

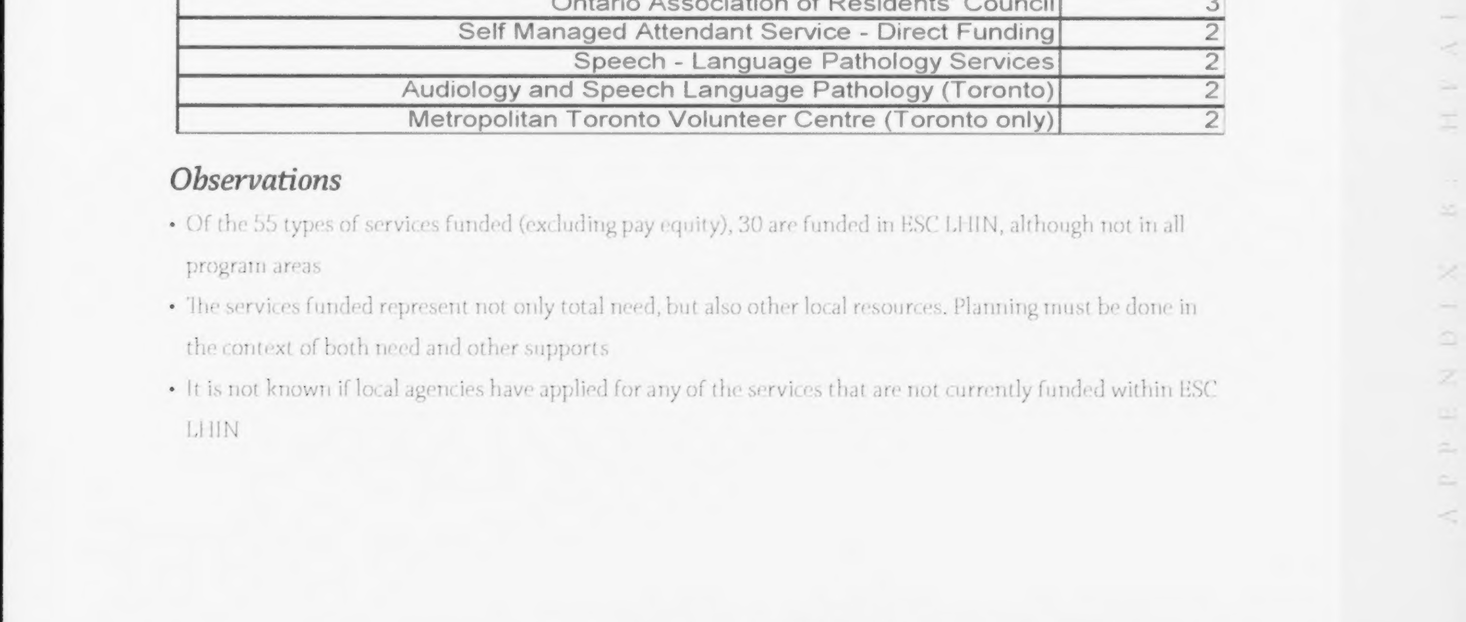
Community Support Services Programs, 2005/6

Not provided in ESC LHIN, but provided in Ontario

Service	Funded in Ontario
Proxy Pay Equity	85
Home Maintenance and Repair (First Nations Only)	51
Home Help/Homemaking (brokerage)	43
Social Recreational Service	40
Community & Facility Palliative Care Interdisciplinary Ed	26
Independence Training - Physically Disabled Adults	18
Homemaking/Personal Supp/Attendant/Respite-FirstNat Outreach	17
Caregiver Support (brokerage)	15
Aboriginal Support Service	15
Supportive Living Service - ABI Outreach	14
Pain and Symptom Management	14
Emergency Response Systems	13
Independence Training - ABI Outreach	13
Psychological Services - ABI	10
Physician Palliative Care Education	9
Homemaking/Personal Supp/Attendant - HIV/AIDS in SHU	8
Nursing	7
Occupational Therapy	7
Social Work	5
Homemaking/Personal Supp/Attendant/Respite -CCAC Outreach	4
Physiotherapy	4
Aphasia Service	3
Ontario Association of Residents' Council	3
Self Managed Attendant Service - Direct Funding	2
Speech - Language Pathology Services	2
Audiology and Speech Language Pathology (Toronto)	2
Metropolitan Toronto Volunteer Centre (Toronto only)	2

Observations

- Of the 55 types of services funded (excluding pay equity), 30 are funded in ESC LHIN, although not in all program areas
- The services funded represent not only total need, but also other local resources. Planning must be done in the context of both need and other supports
- It is not known if local agencies have applied for any of the services that are not currently funded within ESC LHIN



Community Support Services, 2004/5

Listed in descending order of Actual Clients in ESC LHIN

	Planning Area											
	Chatham-Kent			Essex			Lambton			ESC LHIN		
Service	Actual Units	Actual Clients	Waiting List	Actual Units	Actual Clients	Waiting List	Actual Units	Actual Clients	Waiting List	Actual Units	Actual Clients	Waiting List
Meals on Wheels	36,467	716		92,639	2,913		29,245	406		158,351	4,035	-
Homemaking/Personal Supp/Attendant/Respite-Phys Dis Outreach	13,770	54	4	37,006	124	5	24,864	67	12	75,640	245	21
Transportation	10,846	546		38,639	1,472	5	18,311	698		67,796	2,716	5
Security Checks/Reassurance Service	608	16	1	15,478	435	2	20,011	78		36,097	529	3
Supportive Living Service - Physically Disabled Adults	6,420	19	16	14,609	41	18	10,290	34	18	31,319	94	52
Homemaking/Personal Supp/Attendant - Elderly in SHU	10,768	9	6	7,327	19					18,095	28	6
Caregiver Support (Paid Staff)	3,996	71		9,337	75		2,328	19		15,661	165	-
Caregiver Support - Volunteer Hospice Visiting Service	2,527	68		10,489	716		2,030	30		15,046	814	-
Friendly Visiting	781	49	45	6,348	177	41	2,919	115	34	10,048	341	120
Home Help/Homemaking (Paid)							9,379	225		9,379	225	-
Diners Club/Wheels to Meals/Congregate Dining				920	38		7,764	542		8,684	580	-
Adult Day Service-Integrated-Frail/Alzheimers/Other Dementia	1,206	55		4,366	102	1	2,863	54		8,435	211	1
Foot Care	1,020	85		5,750	1,543					6,770	1,628	-
Adult Day Service (Alzheimers/Other Aging Dementia)	1,715	160		3,259	140		1,706	62		6,680	362	-
Caregiver Support - Support and Counselling	1,498	415		4,432	2,466					5,930	2,881	-
Home Maintenance and Repair (Brokerage)				8	8		4,601	338	7	4,609	346	7
Client Intervention and Assistance Service (Seniors)							4,268	694		4,268	694	-
Special Services For the Blind and Visually Impaired				3,840	1,384	45				3,840	1,384	45
Public Education Coordinator	1,649	2,046		669	3,092		475	2,009		2,793	7,147	-
Adult Day Service	1,361	58		1,005	20					2,366	78	-
Special Services For Persons with Acquired Hearing Loss				2,218	580	2				2,218	580	2
Supportive Living Service - ABI in SHU				2,190	7	3				2,190	7	3
Caregiver Support - Training, Information and Education	627	1,203		1,375	1,248		182	20		2,184	2,471	-
Caregiver Support (Volunteer)							1,500	56		1,500	56	-
Adult Day Service (Frail Elderly)							1,129	34		1,129	34	-
Extended Respite Service							440	8		440	8	-
Geriatric Assessment Program - Windsor				371	371	75				371	371	75
Psychogeriatric Consulting Services (Alzheimer Strategy)				207	382					207	382	-
Case Management	65	65					70	70		135	135	-
Alzheimers/Dementia Overnight Service							27	4		27	4	-
Combined		5,635	72		17,353	197		5,563	71		28,551	340

Observations

- The Combined row may show some individuals more than once if they are clients of more than one agency and/or one service in an agency
- "Actual Units" are not totalled because different types of units (hours, visits, trips, meals) are used in different services. They are commonly used across services
- ESC LHIN serves 5% of Ontario clients (the columns are not shown)
- ESC LHIN waiting list is only 2.6% of Ontario's waiting list. It is not clear whether this is due to different reporting standards or actual unmet need (the columns are not shown)

Community Support Services, 2004/5

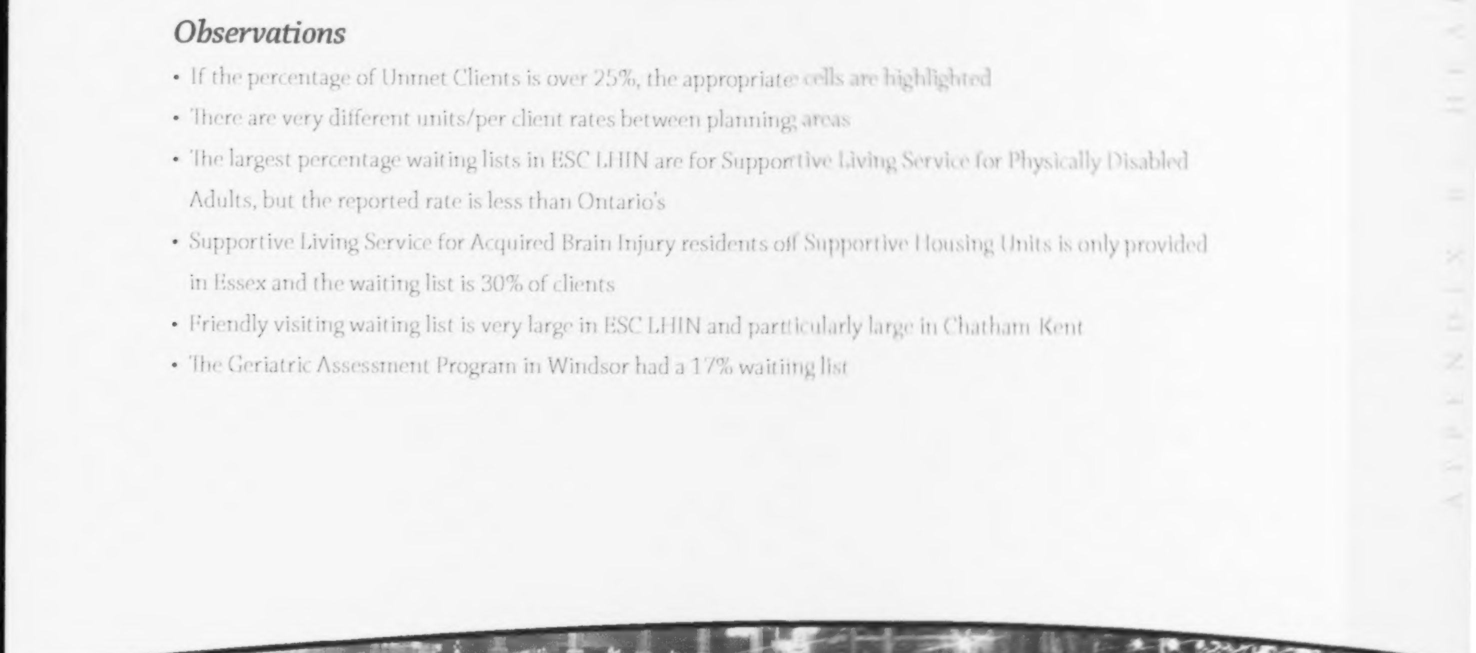
Units per client and waiting list comparisons

Service	Units per Client					% Unmet Clients				
	Chatham-Kent	Essex	Lambton	ESC LHIN	Ontario	Chatham-Kent	Essex	Lambton	ESC LHIN	Ontario
Meals on Wheels	51	32	72	39	64	0%	0%	0%	0%	0%
Homemaking/Personal Supp/Attendant/Respite-Phys Dis Outreach	255	298	371	309	465	7%	4%	15%	8%	41%
Transportation	20	26	26	25	20	0%	0%	0%	0%	2%
Security Checks/Reassurance Service	38	36	257	68	75	6%	0%	0%	1%	1%
Supportive Living Service - Physically Disabled Adults	338	356	303	333	484	46%	31%	35%	36%	57%
Homemaking/Personal Supp/Attendant - Elderly in SHU	1,196	386		646	220	40%	0%		18%	18%
Caregiver Support (Paid Staff)	56	124	123	95	128	0%	0%	0%	0%	3%
Caregiver Support - Volunteer Hospice Visiting Service	37	15	68	18	23	0%	0%	0%	0%	0%
Friendly Visiting	16	36	25	29	14	48%	19%	23%	26%	3%
Home Help/Homemaking (Paid)			42	42	48			0%	0%	2%
Diners Club/Wheels to Meals/Congregate Dining		24	14	15	20		0%	0%	0%	1%
Adult Day Service-Integrated-Frail/Alzheimers/Other Dementia	22	43	53	40	36	0%	1%	0%	0%	6%
Foot Care	12	4		4	4	0%	0%		0%	1%
Adult Day Service (Alzheimers/Other Aging Dementia)	11	23	28	18	45	0%	0%	0%	0%	6%
Caregiver Support - Support and Counselling	4	2		2	3	0%	0%		0%	0%
Home Maintenance and Repair (Brokerage)		1	14	10	6		0%	2%	2%	2%
Client Intervention and Assistance Service (Seniors)			6	6	5			0%	0%	0%
Special Services For the Blind and Visually Impaired		3		3	7		3%		3%	8%
Public Education Coordinator	1	0	0	0	0	0%	0%	0%	0%	0%
Adult Day Service	23	50		30	52	0%	0%		0%	21%
Special Services For Persons with Acquired Hearing Loss		4		4	4		0%		0%	2%
Supportive Living Service - ABI in SHU		313		313	331		30%		30%	30%
Caregiver Support - Training, Information and Education	1	1	9	1	1	0%	0%	0%	0%	0%
Caregiver Support (Volunteer)			27	27	16			2%	2%	9%
Adult Day Service (Frail Elderly)			33	33	36			0%	0%	5%
Extended Respite Service			55	55	255			0%	0%	27%
Geriatric Assessment Program - Windsor		1		1	1		17%		17%	17%
Psychogeriatric Consulting Services (Alzheimer Strategy)		1		1	10		0%		0%	0%
Case Management	1		1	1	2	0%		0%	0%	0%
Alzheimers/Dementia Overnight Service			7	7	20			0%	0%	8%
Combined	-	-	-	-	-	1%	1%	1%	1%	2%

*from "Summary Report on Community Support Services" MOHLTC FIM

Observations

- If the percentage of Unmet Clients is over 25%, the appropriate cells are highlighted
- There are very different units/per client rates between planning areas
- The largest percentage waiting lists in ESC LHIN are for Supportive Living Service for Physically Disabled Adults, but the reported rate is less than Ontario's
- Supportive Living Service for Acquired Brain Injury residents off Supportive Housing Units is only provided in Essex and the waiting list is 30% of clients
- Friendly visiting waiting list is very large in ESC LHIN and particularly large in Chatham Kent
- The Geriatric Assessment Program in Windsor had a 17% waiting list



Community Support Services, 2004/5

Actual Costs per Unit and per Client

	Planning Area									
	Chatham-Kent		Essex		Lambton		ESC LHIN		Ontario	
Program	Actual Cost per Unit	Actual Cost per Client	Actual Cost per Unit	Actual Cost per Client	Actual Cost per Unit	Actual Cost per Client	Actual Cost per Unit	Actual Cost per Client	Actual Cost per Unit	Actual Cost per Client
Adult Day Service (Alzheimers/Other Aging Dementia)	$ 142	$ 1,526	$ 177	$ 4,121	$ 190	$ 5,225	$ 171	$ 3,163	$ 104	$ 4,424
Adult Day Service (Frail Elderly)					$ 139	$ 4,603	$ 139	$ 4,603	$ 83	$ 2,860
Adult Day Service-Integrated-Frail/Alzheimers/Other Dementia	$ 67	$ 1,480	$ 120	$ 5,150	$ 58	$ 3,074	$ 92	$ 3,662	$ 94	$ 3,375
Adult Day Service	$ 152	$ 3,565	$ 254	$ 12,741			$ 195	$ 5,918	$ 97	$ 5,067
Alzheimers/Dementia Overnight Service					$ 701	$ 4,733	$ 701	$ 4,733	$ 272	$ 5,550
Meals on Wheels	$ 10	$ 485	$ 10	$ 320	$ 9	$ 684	$ 10	$ 386	$ 11	$ 702
Diners Club/Wheels to Meals/Congregate Dining			$ 18	$ 447	$ 8	$ 119	$ 9	$ 141	$ 11	$ 223
Transportation	$ 23	$ 466	$ 18	$ 470	$ 34	$ 891	$ 23	$ 577	$ 18	$ 358
Home Maintenance and Repair (Brokerage)			$ 1,823	$ 1,823	$ 18	$ 246	$ 21	$ 282	$ 24	$ 156
Friendly Visiting	$ 58	$ 918	$ 12	$ 429	$ 23	$ 598	$ 19	$ 553	$ 14	$ 194
Security Checks/Reassurance Service	$ 49	$ 1,872	$ 5	$ 175	$ 2	$ 410	$ 4	$ 261	$ 2	$ 162
Caregiver Support - Support and Counselling	$ 94	$ 339	$ 51	$ 92			$ 62	$ 128	$ 69	$ 200
Caregiver Support - Training, Information and Education	$ 122	$ 65	$ 102	$ 113	$ 153	$ 1,394	$ 112	$ 98	$ 39	$ 48
Caregiver Support: Paid Staff	$ 24	$ 1,366	$ 31	$ 3,820	$ 27	$ 3,256	$ 29	$ 2,710	$ 27	$ 3,459
Caregiver Support - Volunteer Hospice Visiting Service	$ 33	$ 1,237	$ 12	$ 173	$ 41	$ 2,764	$ 19	$ 357	$ 20	$ 458
Caregiver Support (Volunteer)					$ 69	$ 1,056	$ 69	$ 1,056	$ 36	$ 571
Extended/Respite Service					$ 88	$ 4,345	$ 88	$ 4,345	$ 24	$ 6,031
Home Help/Homemaking (Paid)					$ 37	$ 1,555	$ 37	$ 1,555	$ 25	$ 1,197
Public Education Coordinator	$ 29	$ 23	$ 93	$ 20	$ 99	$ 23	$ 56	$ 22	$ 84	$ 23
Psychogeriatric Consulting Services: Alzheimer Strategy			$ 173	$ 94			$ 173	$ 94	$ 156	$ 35
Foot Care	$ 30	$ 341	$ 9	$ 33			$ 12	$ 49	$ 23	$ 94
Crisis Intervention and Assistance Service (Seniors)					$ 7	$ 40	$ 7	$ 40	$ 35	$ 162
Geriatric Assessment Program - Windsor			$ 1,893	$ 1,893			$ 1,893	$ 1,893	$ 1,893	$ 1,893
Homemaking/Personal Supp/Attendant - Elderly in SHU	$ 20	$ 23,399	$ 52	$ 19,902			$ 33	$ 21,947	$ 26	$ 5,779
Supportive Living Service - Physically Disabled Adults	$ 103	$ 34,899	$ 143	$ 50,807	$ 132	$ 40,057	$ 131	$ 43,703	$ 83	$ 39,987
Homemaking/Personal Supp/Attendant/Respite-Phys Dis Outreach	$ 30	$ 7,683	$ 30	$ 8,899	$ 27	$ 10,041	$ 29	$ 8,943	$ 33	$ 15,473
Supportive Living Service - ABI in SHU			$ 263	$ 82,349			$ 263	$ 82,349	$ 345	$ 114,354
Case Management	$ 686	$ 686			$ 748	$ 748	$ 718	$ 718	$ 354	$ 539
Special Services For the Blind and Visually Impaired			$ 90	$ 250			$ 90	$ 250	$ 83	$ 367
Special Services For Persons with Acquired Hearing Loss			$ 138	$ 528			$ 138	$ 528	$ 157	$ 552

Observations

- Actual costs per unit and per client vary greatly across program areas
- The most expensive service per client is Supportive Living Service for persons with Acquired Brain Injury at $114,000 per year in Ontario compared to $82,000 in ESC LHIN

2.13.3 Children's Treatment Centres

Definition

- Children's Treatment Centres (CTCs) provide services for children and youth with multiple physical, developmental, and associated behavioural needs. Typically the CTCs engage physiotherapists, occupational therapists, social workers and less frequently, audiologists

Significance/Uses

- CTCs are an important provider of services to some special needs children
- A better understanding of the services they provide and their patients will, when combined with information from CCAC School programs and specialized hospital services, allow for better planning and service provision

Limitations

- The data available was taken from the MIS dataset. More detailed information on patients and services required and received will be needed before concrete plans can be developed
- The data presented do not distinguish between services/children funded by MOHLTC or MCSS/MCYS
- The data presented do not indicate how many children are served by more than one service and therefore individuals under care by site are not available in this report
- Some services are jointly funded by MOHLTC and MCSS/MCYS. Planning and allocation endeavours will require the commitment of MCSS/MCYS

Source

- Children's Treatment Centre MIS Comparative Reports, 2005/06 YE, MOHLTCFIM website August 2006

Children's Treatment Centres, 2005/06

Selected Service Statistics

	Physiotherapy				
Planning Area	Individuals Served	Avg Wait Days Assess	Avg Wait Days Service	Total Cost per Visit	Total Cost per SR WLM*
Chatham-Kent	302	39.9	30	$55.37	$1.17
Essex	470	11.9	-	$70.38	$0.95
Lambton	307	48.7	8	$127.61	$1.39
ESC LHIN	1,079	31	11	$71.50	$1.05
Ontario	11,400	60	115	$104.35	$1.17
Median		48	30	$111.07	$1.29
3rd Quartile		64	51	$145.69	$1.39
90th Percentile		175	252	$166.04	$1.55

*Service Recipient Workload Management

	Occupational Therapy				
Planning Area	Individuals Served	Avg Wait Days Assess	Avg Wait Days Service	Total Cost per Visit	Total Cost per SR WLM
Chatham-Kent	287	146.1	100	$50.35	$0.93
Essex	490	69.8	-	$82.12	$1.01
Lambton	688	488.7	28	$139.86	$1.14
ESC LHIN	1,465	266	28	$79.31	$1.02
Ontario	12,667	110	152	$128.99	$1.26
Median		70	56	$135.62	$1.18
3rd Quartile		130	107	$201.72	$1.34
90th Percentile		299	258	$235.09	$1.89

	Speech Language/Pathology				
Planning Area	**Individuals Served**	**Avg Wait Days Assess**	**Avg Wait Days Service**	**Total Cost per Visit**	**Total Cost per SR WLM**
Chatham-Kent	721	81.3	120	$87.33	$0.65
Essex	294	27.3	-	$74.81	$0.97
Lambton	503	243.6	26	$116.12	$1.27
ESC LHIN	1,518	126	55	$89.30	$0.92
Ontario	10,987	144	101	$113.96	$1.17
Median		121	43	$116.12	$1.11
3rd Quartile		187	115	$214.93	$1.28
90th Percentile		244	295	$234.80	$1.71

	Audiology				
Planning Area	**Individuals Served**	**Avg Wait Days Assess**	**Avg Wait Days Service**	**Total Cost per Visit**	**Total Cost per SR WLM**
Chatham-Kent	1,582	46.5	1	$79.35	$0.59
Essex	-	-	-	-	-
Lambton	663	280.8	-	$89.24	$1.71
ESC LHIN	2,245	130	0.5	$82.55	$0.77
Ontario	3,132	90	0.5	$77.70	$0.77
Median		47	0.5	$79.35	$0.76
3rd Quartile		164	0.8	$84.29	$1.24
90th Percentile		234	0.9	$87.26	$1.52

	Social Work				
Planning Area	**Individuals Served**	**Avg Wait Days Assess**	**Avg Wait Days Service**	**Total Cost per Visit**	**Total Cost per SR WLM**
Chatham-Kent	203	66.8	60	$46.69	$0.93
Essex	385	3.7	-	$56.51	$0.89
Lambton	168	125.2	3	$696.86	$2.78
ESC LHIN	756	42	10	$62.66	$1.04
Ontario	7,202	89	111	$124.92	$1.29
Median		63	11	$128.99	$1.17
3rd Quartile		102	46	$277.01	$1.46
90th Percentile		150	157	$464.48	$1.84

Children's Treatment Centres, 2005/06

Wait Times for assessment + Service

Planning Area	**Physiotherapy**	**Occupational Therapy**	**Speech Language/Pathology**	**Audiology**	**Social Work**
Chatham-Kent	0.40	0.94	0.82	0.52	0.63
Essex	0.07	0.27	0.11	-	0.02
Lambton	0.32	1.97	1.10	3.09	0.64
ESC LHIN	0.24	1.12	0.74	1.44	0.26
Ontario	1.00	1.00	1.00	1.00	1.00
Ontario Average	175	263	244	91	200

Observations

- Chatham-Kent average waiting time for physiotherapy is much lower than the Ontario time, along with audiology. Speech Language Pathology (SLP) is lower and occupational therapy is slightly lower than the Ontario average waiting times
- Essex average waiting times are low compared to Ontario for physiotherapy, occupational therapy, social work and SLP
- Lambton average waiting time for physiotherapy is much lower than the Ontario average, but waiting times for occupational therapy and audiology are very high. SLP services average waiting time is similar to Ontario's
- Although caution must be exercised, the mis-calculated total costs per visit indicate that Lambton CTC is highest cost provider for each type of service. It is assumed (but not confirmed) that the total cost per visit for social worker is misstated

2.13.4 Substance Abuse and Problem Gambling

Definition

- Services as identified by Drug and Alcohol Treatment Information System (DATIS) in July 2006
- Admissions refer to clients who are admitted for service by an agency. One person may be registered in more than one program at a time but are counted only as one admission to that agency. Volumes shown include both persons who have been discharged and those who are still under care at the end of the period. The process for determining an "admission" is the same as for hospitals

Significance/Uses

- Utilization data at the LHIN level is very useful in developing comprehensive service plans
- Although determination of underlying need for services is very hard to quantify, comparison of DATIS clients with those in hospital ERs can begin to build a better picture of need

Limitations

- This is a dataset that has not been intensively used in the past by planning bodies and as such has not received the scrutiny afforded other administrative datasets. Data quality is unknown
- DATIS does not provide unique identifiers (such as a Health Card Number) in their collection process. This provides a severe limitation in reviewing DATIS services
- Access to DATIS information is challenging, again limiting its usefulness in planning and in future allocation processes

Source

- DATIS information provided based on July 2006 data

MOHLTC Funded Substance Abuse and Ptoblam Gambling Agencies, 2005/6*

Planning Area	Agency	Service	Substance Abuse	Problem Gambling
Chatham-Kent	Chatham-Kent Addictions Program (C-KAP)	Initial Assessment Treatment Planning	1	1
		Case Management	1	1
		Community Treatment	1	1
	Westover Treatment Centre	Community Treatment	1	
Essex	House of Sophrosyne	Initial Assessment Treatment Planning	1	
		Community Treatment	1	
		Residential Treatment Services	1	
	Windsor Regional Hospital/Mental Health and Addiction Programs	Initial Assessment Treatment Planning	1	
		Case Management	1	
		Community Treatment	1	
		Residential Withdrawal Management Services Level 1	1	
	Windsor Regional Problem Gambling Services	Initial Assessment Treatment Planning		1
		Case Management		1
		Community Treatment		1
		Community Day/Evening Treatment Services		1
		Residential Treatment Services		1
	Brentwood Recovery Home	Residential Treatment Services	1	
Lambton	Lambton County Addiction Services	Initial Assessment Treatment Planning	1	1
		Case Management	1	1
		Community Treatment	1	1
		Community/Medical Psychiatric Treatment Services	1	
		Community Day/Evening Treatment Services	1	

*DATIS, CATALYST July 2006 for ESC LHIN facilities

Program Distribution with ESC LHIN, 2005/6*

Program	Chatham-Kent	Essex	Lambton	ESC LHIN
Initial Assessment Treatment Planning	1	3	1	5
Case Management	1	2	1	4
Community Treatment	2	3	1	6
Community Day/Evening Treatment Services		1	1	2
Community/Medical Psychiatric Treatment Services			1	1
Residential Withdrawal Management Services Level 1		1		1
Residential Treatment Services		3		3
Community Withdrawal Management Services	offered in Ontario, but not ESC LHIN			
Residential Support Treatment Services	offered in Ontario, but not ESC LHIN			
Residential Medical/Psychiatric Treatment Services	offered in Ontario, but not ESC LHIN			

*DATIS, CATALYST July 2006 for ESC LHIN facilities

Observations

- There are elements of a substance abuse and problem gambling programs available in each planning area
- Not all programs offered in all communities (Community Day/Evening Treatment services not in Chatham-Kent, only one residential Withdrawal Management System in Windsor,three residential treatment services in Windsor)
- Three residential (home) based services not offered at all in ESC LHIN

New Admissions for Substance Abuse or Problem Gambling, ESC LHIN services, 2005/6*

	Substance Abuse	Problem Gambling	Combined**
Male	1,971	178	2,144
Female	963	190	1,150
Total	2,934	368	3,294
Age Groups			
<16	82	6	87
16-24	535	23	557
25-34	805	62	865
35-54	1,367	200	1,564
55-64	107	45	151
65+	38	32	70

*DATIS, CATALYST July 2006 for ESC LHIN facilities

**some new admissions may receive both services but are counted once in "Combined"

Residence of Client, 2005/6*

	Treated in ESC LHIN			Treated Outside ESC LHIN		
Residence	**Substance Abuse**	**Problem Gambling**	**Combined****	**Substance Abuse**	**Problem Gambling**	**Combined****
Chatham-Kent	425	21	444	495	27	520
Essex	1,856	312	2,167	786	18	804
Lambton	625	35	655	96	3	98
ESC LHIN	2,906	368	3,266	1,377	48	1,422
Non-ESC LHIN	28	-	28	75,517	3,379	78,468

*DATIS, CATALYST July 2006 for ESC LHIN facilities

**some new admissions may receive both services but are counted once in "Combined"

Observations

- 2,934 new admissions in 2005/06 for the seven funded substance abuse services in ESC LHIN
- 368 new admissions in 2005/06 to the five funded problem gambling agencies in ESC LHIN

- Substance Abuse clients are younger, with only 5% aged 55 years and older
- Problem gambling clients are concentrated in the 25 to 54 year old group (91%)
- 54% of the Chatham Kent substance abuse clients are served outside ESC LHIN
- 30% of the Essex substance abuse clients are served outside ESC LHIN
- Only 13% of Lambton substance abuse clients are served outside ESC LHIN
- 56% of Chatham-Kent problem gambling clients are served outside the ESC LHIN
- Under 10% of Essex and Lambton problem gambling clients are served outside ESC LHIN

Legal Status of Clients, 2005/6*

Legal Status	Substance Abuse	Problem Gambling	Combined**
No Problem	78%	95%	80%
Awaiting trial or sentencing	7%	2%	7%
Probation	10%	1%	9%
Parole	0.2%	0.3%	0%
Incarcerated	0.1%	0.3%	0%

*DATIS, CATALYST July 2006 for ESC LHIN facilities

**some new admissions may receive both services but are counted once in "Combined"

Selected and Aggregated Referral Sources, 2005/6*

Source	Substance Abuse	Problem Gambling	Combined**
Self/Family/Friends	58%	68%	59%
SA/PG agencies	11%	7%	11%
Hospitals	6%	2%	6%
CHC	0%	0%	0%
Other	25%	23%	24%

*DATIS, CATALYST July 2006 for ESC LHIN facilities

**some new admissions may receive both services but are counted once in "Combined"

Observations

- 78% of ESC LHIN substance abuse clients are not involved in the criminal justice system at the time of admission
- 95% of ESC LHIN problem gambling clients are not involved in the criminal justice system at the time of admission
- Most referrals are self or family or friend generated for both substance abuse (58%) and problem gambling (68%)

- Hospitals refer only 6% of substance abuse admissions
- CHC's refer less than 0.5% of substance abuse admissions
- No waiting list admission information is available for HSP use at this time

STRUCTURE OF THE HEALTH CARE SYSTEM

SECTION 3

3.1 Inventory of Health Services in the ESC LHIN

Definition

- List of health services funded by the MOHLTC in the ESC LHIN 2005/06
- List of independent health facilities in the ESC LHIN 2005/06

Significance/Uses

- Provides basic information on the availability of different types of services in an area
- Indicator of the distribution and accessibility of health programs and services in an area

Limitations

- Inventory includes only MOHLTC-funded organizations
- Inventory of organizations does not measure their capacity or the volume of services they provide
- Further efforts will be undertaken within the next few months to ensure these inventories are complete and representative of all the services provided within the Erie St. Clair LHIN

Source

- MOHLTC

Inventory of Existing Health Services Funded by MOHLTC in the ESC LHIN 2005/06

Program	Facility	Location
Acquired Brain Injury (ABI)	Brain Injury Association of Chatham	Chatham-Kent
	Association for Persons with Physical Disabilities of Windsor and Essex County	Essex
Assisted Living Services in Supportive Housing (ALSSH)	Community Health Services – Canadian Red Cross, Chatham-Kent Branch	Chatham-Kent
	Ontario March of Dimes, Chatham Branch	Chatham-Kent
	Association for Persons with Physical Disabilities of Windsor and Essex County	Essex
	Corporation of the City of Windsor	Essex
	Corporation of the County of Essex – Sun Parlor Home	Essex
	Leamington United Mennonite Home & Apartments	Essex
	Victorian Order of Nurses for Canada – Ontario Branch Windsor-Essex	Essex
	Windsor Jewish Community Centre	Essex
	Ontario March of Dimes, Sarnia Branch	Lambton
Community Care Access Centres (CCAC)	Chatham-Kent Community Care Access Centre	Chatham-Kent
	Windsor/Essex Community Care Access Centre	Essex
	Sarnia Lambton Community Care Access Centre	Lambton
Community Health Centres (CHC)	Grand Bend Area Community Health Centre Inc.	Lambton
	North Lambton Community Health Centre	Lambton
	Sandwich Community Health Centre Inc.	Essex
	The Phoenix Wholistic Health Centre (Operating as the Teen Health Centre)	Essex
Community Support Services (CSS)	Alzheimer Society of Chatham-Kent	Chatham-Kent
	Blenheim & Community Senior Citizens Group – Meals on Wheels Program	Chatham-Kent
	Brain Injury Association of Chatham-Kent	Chatham-Kent
	Family Service Kent	Chatham-Kent
	Maple City Centre for Older Adults o/a Active Lifestyle Centre	Chatham-Kent
	Meals on Wheels (Chatham) Inc.	Chatham-Kent
	Meals on Wheels (Dresden) Inc.	Chatham-Kent
	Meals on Wheels Ridgetown	Chatham-Kent
	Morpeth Heritage 60+ Club	Chatham-Kent
	Ontario March of Dimes Chatham Branch	Chatham-Kent
	Ridgetown and Area Adult Activity Centre	Chatham-Kent
	St. Andrew's Residence, Chatham Inc.	Chatham-Kent
	Thamesville Happy Club	Chatham-Kent
	Tilbury & District Senior Adult Centre Association (Leisure Centre)	Chatham-Kent
	Tilbury Information & Help Centre	Chatham-Kent
	Victorian Order of Nurses for Canada – Ontario Branch Chatham-Kent	Chatham-Kent
	Wallaceburg Senior Citizens' Club Inc.	Chatham-Kent
	Wheatley and District Friendship Club Inc.	Chatham-Kent

Program	Facility	Location
Community Support Services (cont.)	Alzheimer Society of Windsor and Essex County	Essex
	Amherstburg Community Services	Essex
	Association for Persons with Physical Disabilities of Windsor and Essex County	Essex
	Centres for Seniors Windsor	Essex
	Citizen Advocacy Windsor Essex	Essex
	Club DeL'Age D'Or Le Foyer Pointe-Aux-Roches	Essex
	Essex Community Services	Essex
	Essex Retirees Social Club	Essex
	Essex Retirees Social Club – EPC	Essex
	Fort Malden Golden Age Centre	Essex
	Good Neighbour Club of Belle River and area	Essex
	Hospice of Windsor and Essex County Inc. (The)	Essex
	Lakeshore Community Services	Essex
	Leamington and District Half-Century Centre	Essex
	South Essex Community Council Incorporated	Essex
	Tecumseh Golden Age Club	Essex
	Tecumseh Seniors Transit Inc.	Essex
	The Canadian Hearing Society – Windsor Region	Essex
	The Canadian National Institute for the Blind – Ont. Div. – Windsor District	Essex
	Victorian Order of Nurses for Canada – Ontario Branch Windsor-Essex	Essex
	Windsor Jewish Community Centre	Essex
	Windsor Regional Hospital (GAP/ADC)	Essex
	Alzheimer Society of Sarnia-Lambton	Lambton
	Chippewas of Kettle and Stony Point Home Support Program	Lambton
	Corporation of the City of Sarnia – Strangway Community Centre for Adults 50+	Lambton
	Corporation of the County of Lambton – Senior Services	Lambton
	Lambton Elderly Outreach Incorporated	Lambton
	Moore Presbyterian Foundation – Cruickshank Centre	Lambton
	Ontario March of Dimes – Sarnia Branch	Lambton
	Sarnia and District Senior Volunteer Community Services	Lambton
	Social Service Bureau – Family Counselling Centre	Lambton
	The Canadian Red Cross Ontario Zone, Sarnia Lambton Branch	Lambton
	Victorian Order of Nurses for Canada – Ontario Branch Sarnia-Lambton	Lambton
	Walpole Island First Nation	Lambton
Hospitals	Chatham-Kent Health Alliance	Chatham-Kent
	-The Public General Hospital Society of Chatham	
	-St. Joseph's Health Services Association of Chatham, Incorporated	
	-Sydenham District Hospital, Wallaceburg	
	Hotel-Dieu Grace Hospital, Windsor	Essex
	Leamington District Memorial Hospital	
	Windsor Regional Hospital	
	Bluewater Health	Lambton

Program	Facility	Location
Long Term Care Homes (LTC)	Blenheim Community Village	Chatham-Kent
	Copper Terrace	Chatham-Kent
	Fairfield Park	Chatham-Kent
	Meadow Park Chatham	Chatham-Kent
	Riverview Gardens	Chatham-Kent
	The Village Ridgetown	Chatham-Kent
	Tilbury Manor Nursing Home	Chatham-Kent
	Banwell Gardens	Essex
	Brouillette Manor	Essex
	Chateau Park Nursing Home	Essex
	Country Village Health Care Centre	Essex
	Extendicare/Southwood Lakes	Essex
	Extendicare/Tecumseh	Essex
	Heron Terrace	Essex
	Huron Lodge	Essex
	Leamington Mennonite Home	Essex
	Leamington Nursing Home	Essex
	The Royal Oak Long Term Care Centre	Essex
	Regency Park Nursing/Retirement Centre	Essex
	Richmond Terrace	Essex
	Riverside Health Care Centre	Essex
	Sun Parlor Home for Senior Citizens	Essex
	Versa-Care Iler Lodge	Essex
Long Term Care Homes (LTC) (cont.)	Versa-Care Windsor Place	Essex
	Afton Park Place	Lambton
	Fiddick's Nursing Home	Lambton
	Lambton Meadowview Vill	Lambton
	Marshall Gowland Manor	Lambton
	North Lambton Rest Home	Lambton
	Sumac Lodge	Lambton
	Trillium Villa Nursing Home	Lambton
	Twin Lakes Terrace	Lambton
	Vision Nursing Home	Lambton
	Watford Quality Care Centre	Lambton
Mental Health (Addictions)	Chatham-Kent Addiction Program	Chatham-Kent
	Westover Treatment Centre, Thamesville	Chatham-Kent
	House of Sophrosyne	Essex
	Withdrawal Management Centre	Essex
	Bluewater Health	Lambton
	Lambton County Addiction Services	Lambton
Mental Health (Supportive Housing)	Brentwood Treatment Centre	Essex
	Canadian Mental Health Association, Windsor-Essex County Branch	Essex
	Canadian Mental Health Association, Lambton County Branch	Lambton

Program	Facility	Location
Mental Health (Programs)	Canadian Mental Health Association, Chatham-Kent Branch	Chatham-Kent
	Chatham-Kent Consumer/Survivor Network	Chatham-Kent
	The Public General Hospital Society of Chatham	Chatham-Kent
	Bulimia Anorexia Nervosa Association	Essex
	Canadian Mental Health Association, Windsor-Essex County Branch	Essex
	Community Crisis Centre of Windsor-Essex County	Essex
	Mental Health Connections	Essex
	Mental Health Consumer/Survivor Employment Association of Essex County	Essex
	Sexual Assault Crisis Centre of Essex County Inc.	Essex
	The Hospice of Windsor-Essex County Inc.	Essex
	Windsor Regional Hospital	Essex
	Canadian Mental Health Association, Lambton County Branch	Lambton
	Family Counselling Centre	Lambton

The above table lists the inventory of health services funded by the Ministry of Health and Long Term Care within ESC LHIN for the 2005/06 fiscal year. There are 131 programs and services aligned as follows:

- two Acquired Brain Injury (ABI) programs, one in Chatham-Kent and one in Essex County
- nine Assisted Living Services in Supportive Housing (ALSSH), two in Chatham-Kent, six in Essex and one in Lambton
- three Community Care Access Centres (CCAC), one administration serves both Chatham Kent and Sarnia Lambton and one serves Essex County
- four Community Health Centres (CHC), two in Essex and two in Lambton
- 52 Community Support Services (CSS), 18 in Chatham-Kent, 22 in Essex, 12 in Lambton
- Five hospitals, one in Chatham-Kent (Chatham-Kent Health Alliance), three in Essex (Leamington District Memorial Hospital, Hotel Dieu Grace Hospital, and Windsor Regional Hospital), one in Lambton (Bluewater Health)
- 34 Long Term Care Homes, seven in Chatham-Kent, (after merging of two facilities in 2006), 17 in Essex (after closures in 2006) and 10 in Lambton
- six Mental Health Addictions programs, two in Chatham-Kent, two in Essex and two in Lambton
- three Mental Health Supportive Housing programs, two in Essex, one in Lambton
- 13 other Mental Health programs, three in Chatham-Kent, eight in Essex and two in Lambton

In addition, three Children's Treatment Centres (CTC) programs exist, one in Chatham-Kent, one in Essex and one in Lambton; however, these programs are now partially funded by other ministries. Further information on these programs will be discussed in Section 2.13 Community Care Utilization.

INDEPENDENT HEALTH FACILITIES

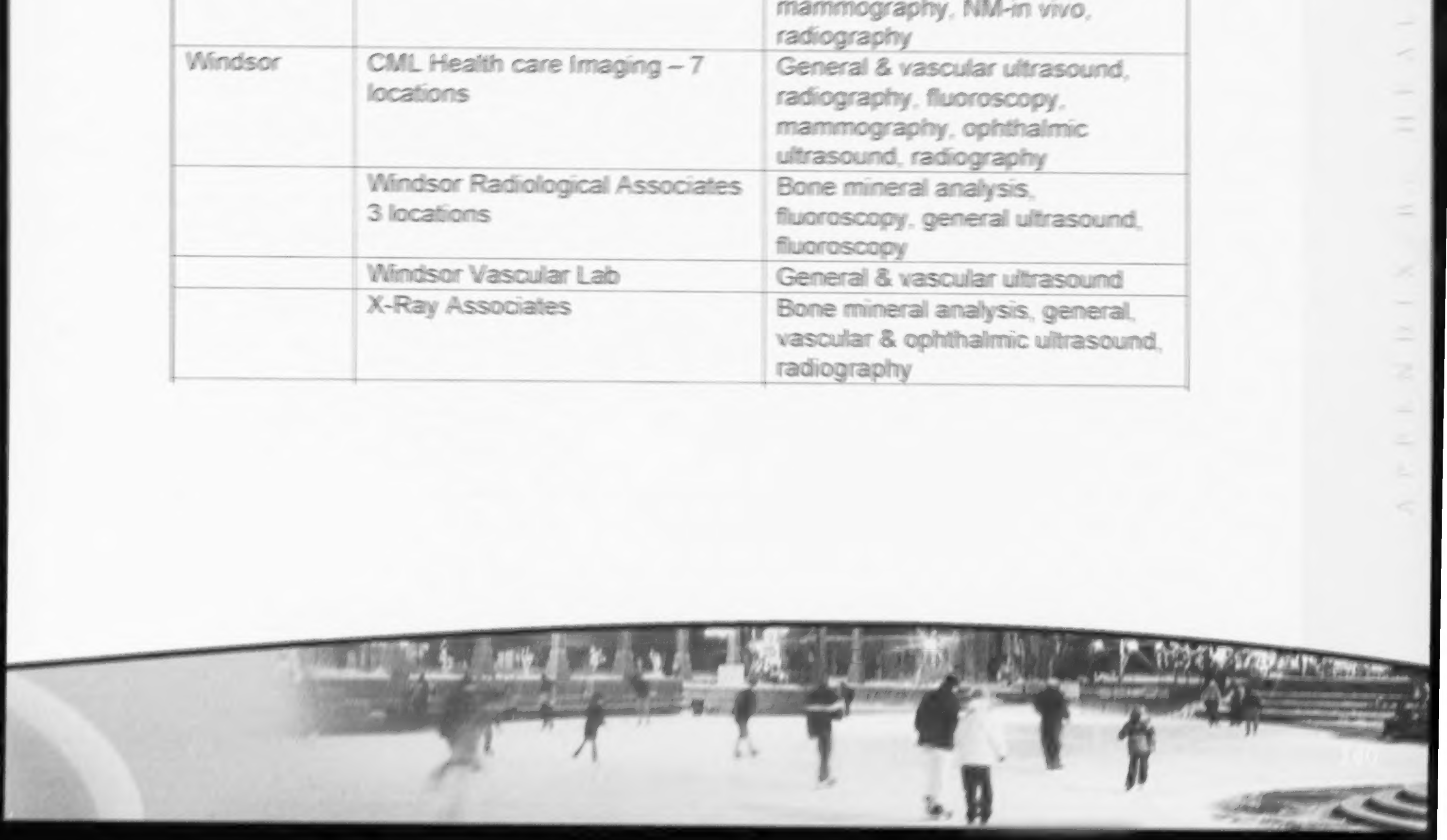
Location	Facility Name	Services Offered

Chatham-Kent

Location	Facility Name	Services Offered
Chatham	Medi-Share Diagnostic Imaging	Mammography, general & vascular ultrasound, radiography
	Dr. Robert G. McMahon	Ophthalmic ultrasound

Essex County

Location	Facility Name	Services Offered
Amherstburg	Essex X-Ray	Radiography, general & vascular ultrasound
Essex	CML Health care Imaging	General ultrasound
Kingsville	CML Health care Imaging	Bone mineral analysis, radiography, general ultrasound, mammography
LaSalle	CML Health care Imaging	Fluoroscopy, general & vascular ultrasound, mammography, NM-in vivo, radiography
Tecumseh	Windsor Radiological Associates	Radiography
	Essex X-Ray	Bone mineral analysis, general & vascular ultrasound, mammography, NM-in vivo, radiography
Windsor	CML Health care Imaging – 7 locations	General & vascular ultrasound, radiography, fluoroscopy, mammography, ophthalmic ultrasound, radiography
	Windsor Radiological Associates 3 locations	Bone mineral analysis, fluoroscopy, general ultrasound, fluoroscopy
	Windsor Vascular Lab	General & vascular ultrasound
	X-Ray Associates	Bone mineral analysis, general, vascular & ophthalmic ultrasound, radiography



Essex County (cont'd)

	X-Ray Associates II	Radiography
	Anwist Diagnostics Inc	Pulmonary function studies
	Iannicello, Dr. Carman	Vascular ultrasound
	Essex X-Ray	Fluoroscopy, general & vascular ultrasound, mammography, radiography
	Brian Curran M.D.	Ophthalmic ultrasound
	Windsor Sleep Disorders Clinic	Sleep studies
	Tecumseh Imaging Associates	General ultrasound, radiography
	Essex X-Ray East	Radiography

Lambton County

Corunna	Corunna X-Ray Services	General ultrasound, radiography
Point Edward	Bluewater Radiology	Fluoroscopy, Radiography, general ultrasound.
	Bluewater Sleep Disorder Clinic	Pulmonary function studies, sleep studies
Sarnia	London Road Diagnostic Clinic	Bone mineral analysis, general & vascular ultrasound, mammography, radiography
	Lambton X-Ray Associates	Bone mineral analysis, general & vascular ultrasound, mammography, radiography

3.2 Hospital Beds by Category

Definition

- Beds staffed and in operation, by hospitals in a given area and by type of care

Significance/Uses

- Provides information on hospital inpatient capacity
- Beds per population rates are an indicator of inpatient hospital care provision

- For some types of care, beds per population ratios can be compared to the MOHLTC planning guidelines
- Comparisons over time and place

Limitations

- Measure of capacity but does not provide information on the efficient use of the beds
- In previous reports the acute care beds and bed rates included mental health beds, but for this report mental health beds have been separated out of the total acute care beds

Source

- Planning Decision Support Tool (PDST, MOHLTC 2003/04 - 2004/05) FIM Daily Census Reports 2005/06

Three Year Trend of the Average Number of Beds Staffed and In Operation at Fiscal Year-End by Type of Bed 2003/04 – 2005/06, Projected Bed Capacity 2006/07

Year	Acute Care	Mental Health	Complex Continuing Care	Rehabilitation	Total

Chatham-Kent

2003/04	168	20	44	22	254
2004/05	172	20	46	22	260
2005/06	165	20	51	21	257
2006/07*	167	21	70	23	281

Essex

2003/04	529	81	102	75	787
2004/05	502	83	107	79	771
2005/06	512	81	122	77	792
2006/07*	571**	88**	172	80	911

Lambton

2003/04	182	27	83	27	319
2004/05	182	27	83	27	319
2005/06	184	27	83	27	321
2006/07*	184	27	82	27	320

ESC LHIN

2003/04	879	128	229	124	1,360
2004/05	856	130	236	128	1,350
2005/06	861	128	256	125	1,370
2006/07*	924	136	321	130	1,511

Source: PDST 2003/04 – 2004/05, MOHLTC FIM Daily Census Reports 2005/06

*Projected bed capacity 2006/07-ESC LHIN Decision Support Team August 2006

**Essex Acute beds exclude NICU

**Essex Mental Health beds include six paediatric Mental Health beds at the Maryvale site.

The above table represents average beds staffed and in operation for the fiscal years 2003/04 through 2005/06. The movement of programs and services between and among sites, as well as temporary bed closures, are among the factors impacting these numbers. The projected bed capacity for 2006/07* is based upon information provided by hospital representatives on the ESC LHIN Decision Support Team in August of 2006. The information is presented here for discussion and planning purposes and may be subject to change.

Observations

In 2005/2006, the total average hospital beds staffed and in operation across the ESC LHIN were 1,370 – consisting of 861 acute beds (excluding mental health), 128 mental health beds, 256 complex continuing care and 125 rehabilitation beds. The projected total hospital bed capacity for 2006/2007 is 1,511 – consisting of 924 acute beds (excluding mental health), 136 mental health beds, 321 complex continuing care beds and 130 rehabilitation beds.

- Acute care beds in Chatham-Kent decreased slightly for 2005/06 and with some further movement of beds projected for later this fiscal year, acute care bed capacity is expected to stabilize at 167, 147 of which are at the Chatham site and 20 at the Sydenham site in Wallaceburg
- There have been changes in the Complex Continuing Care service, with an overall increase from 46 beds in 2004/2005 to 70 projected for 2006/07. 49 of the CCC beds will be located at the Sydenham site in Wallaceburg and 21 of the beds at the Chatham site
- Over the past three years, there has been significant restructuring of Essex County hospital beds, with

programs and services transferred between Hotel-Dieu Grace Hospital and Windsor Regional Hospital. The bed numbers at Leamington District Memorial Hospital have remained stable since the addition of eight acute beds in January of 2005 to the existing complement

- Acute care bed capacity is projected to increase to 571 (from approximately 512 beds), 215 of the beds are located at Hotel-Dieu Grace and 292 of the beds are at Windsor Regional Hospital (excluding NICU), and 64 beds at Leamington District Memorial Hospital
- Mental health bed capacity has increased to 88 beds, 39 of which are at Hotel Dieu Grace and 49 assigned to Windsor Regional Hospital (includes six paediatric mental health beds at Maryvale)
- There has been an increase in the number of Complex Continuing Care beds with capacity now at 172. 153 beds are at Windsor Regional and 19 beds at Leamington District Memorial Hospital
- Rehabilitation bed capacity remains relatively constant at 80 beds, 24 of which are at Hotel Dieu Grace, 50 at Windsor Regional, and 6 at Leamington District Memorial Hospital
- The bed capacity in Lambton has remained relatively stable over the last three years following restructuring efforts in previous years
- An acute care bed capacity of 184 is composed of 161 beds at the Sarnia location and 23 at the Charlotte Eleanor Englehart site in Petrolia
- Mental health bed capacity remains at 27, all located at the Sarnia site
- Complex Continuing Care bed capacity of 82 consists of 70 beds at the Sarnia site and 12 beds at the CEE site in Petrolia
- Rehabilitation bed capacity is 27, located at the Sarnia site

Acute Beds Staffed and in Operation at Fiscal Year End per 100,000 Population by County, ESC LHIN and Ontario 2003/04 – 2005/06, Projected to 2009

Year	Chatham-Kent	Essex	Lambton	ESC LHIN	Ontario
2003/04	155.6	135.9	141.1	140.4	152.5
2004/05	159.3	124.9	141.1	133.9	150.7
2005/06	151.4	126.7	139.4	133.3	146.4
2006/07*	*153.2*	*139.3*	*139.4*	*141.9*	*N/A*
2009/10*	*154.6*	*134.4*	*139.4*	*139.0*	*N/A*

Mental Health Beds Staffed and in Operation at Fiscal Year End per 100,000 Population by County, ESC LHIN and Ontario 2003/04 – 2005/06, Projected to 2009

Year	Chatham-Kent	Essex	Lambton	ESC LHIN	Ontario
2003/04	18.5	20.8	20.9	20.4	40.4
2004/05	18.7	20.6	20.9	20.3	39.5
2005/06	18.3	20.0	20.5	19.8	38.7
2006/07*	*19.3*	*21.5*	*20.5*	*20.9*	*N/A*
2009/10*	*19.4*	*20.7*	*20.5*	*20.5*	*N/A*

Complex Continuing Care Beds Staffed and in Operation at Fiscal Year End per 1,000 Population Age 75+ by County, ESC LHIN and Ontario 2003/04 – 2005/06, Projected to 2009

Year	Chatham-Kent	Essex	Lambton	ESC LHIN	Ontario
2003/04	5.7	4.4	8.7	5.7	9.4
2004/05	5.7	4.5	8.4	5.6	8.9
2005/06	6.2	5.0	8.2	6.0	8.2
2006/07*	*8.5*	*6.9*	*8.0*	*7.4*	*N/A*
2009/10*	*8.5*	*6.6*	*7.7*	*7.1*	*N/A*

Rehabilitation Beds Staffed and in Operation at Fiscal Year End per 100,000 Population by County, ESC LHIN and Ontario 2003/04 – 2005/06, Projected to 2009

Year	Chatham-Kent	Essex	Lambton	ESC LHIN	Ontario
2003/04	20.9	19.7	20.4	19.6	19.3
2004/05	20.9	19.7	20.5	20.0	19.3
2005/06	19.3	19.0	20.5	19.3	19.7
2006/07*	*21.1*	*19.5*	*20.5*	*20.0*	*N/A*
2009/10*	*21.3*	*18.8*	*20.5*	*19.6*	*N/A*

Source

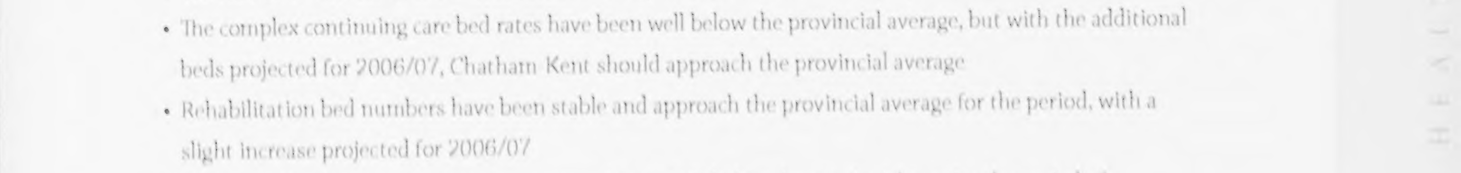
- PDST 2003/04 – 2004/05, MOHLTC FIM Daily Census Reports 2005/06,*Projections: 2006/07 based upon

ESC LHIN Decision Support Team bed projections and 2006 Ministry of Finance population projections 2009/10 based upon the 2006/07 bed projections and 2010 Ministry of Finance population projections. *The above tables represent the average beds staffed and in operation per 100,000 population throughout the ESC LHIN for the periods of 2003/04 to 2005/06 compared to Ontario. It should be noted that Complex Continuing Care bed rates are based on population per 1,000 aged 75+. The projected rates are also shown for 2006/07 (based on expected capacity) and 2009/10.*

Observations

Overall, the provincial bed rates per 100,000 population have been declining for the period from 2003/04 – 2005/06 in acute care, mental health and complex continuing care while remaining relatively stable for rehabilitation. Although the 2006/2007 projected bed capacity for Ontario is unknown, the calculated rates for the three planning areas based on current information, is presented for discussion and planning purposes.

- The number of beds staffed and in operation per 100,000 population has consistently been below that of the province in acute care, mental health and complex continuing care beds but very similar to the province for rehabilitation beds. With the projected increase in bed capacity for 2006/2007, rates are expected to improve in acute care and complex continuing care, depending upon the ability to staff and operate the additional beds
- Chatham-Kent acute care bed rate has remained higher than the provincial rate for the period. This trend will likely continue based on the projected beds for 2006/07
- The mental health bed rate has remained relatively stable, but well below the provincial average
- The complex continuing care bed rates have been well below the provincial average, but with the additional beds projected for 2006/07, Chatham-Kent should approach the provincial average
- Rehabilitation bed numbers have been stable and approach the provincial average for the period, with a slight increase projected for 2006/07
- The Essex County acute bed rate has averaged 14 – 17% below the provincial rate for the period of 2003/2004 to 2005/2006. Fluctuation in bed numbers is observed
- With the projected bed capacity for 2006/2007, the picture improves for Essex County relative to previous provincial rates
- Mental health bed ratios have remained relatively constant, but well below the Ontario average
- Complex continuing care bed ratios remain below that of the province
- Rehabilitation bed rates have remained stable and are very similar to the provincial average
- Acute care bed rates in Lambton have averaged 5 – 7% below provincial rates for the periods shown and are expected to remain the same for 2006/2007
- Mental health rates have remained fairly stable over the period, but well below the provincial average
- Complex continuing care bed rates for Lambton have remained relatively stable and are very similar to the province



- Rehabilitation bed rates have remained stable and are observed slightly above the provincial average

3.3 Long Term Care Home Capacity

Definition

- Number of long term care (LTC) home beds per 1000 population aged 75+

Significance/Uses

- Indicator of LTC utilization that measures the level of residential care the population is receiving, specifically targeted to the population age 75 years and older
- Provides comparison to the MOHLTC guidelines
- Comparison over time and place

Limitations

- Indicator is calculated for the population 75 years of age and older, although some LTC beds are used by patients younger than 75 years
- The system captures only limited demographic data for residents

Source

- PDST 2003/04 – 2004/05, CCAC, Chatham – Kent, Sarnia – Lambton, Windsor – Essex

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Long Term Care Homes Capacity 2003/04 – 2005/06

Location	2003/04			2004/05			2005/06*		
	# of facilities	# beds	Beds/1000 Population 75+	# of facilities	# beds	Beds/1000 Population 75+	# of facilities	# beds	Beds/1000 Population 75+
Chatham -Kent	8	842	106	8	842	104	8	847	103
Essex	20	2,238	96	20	2,410	101	18	2,310	95
Lambton	11	1,044	109	11	1,044	106	10	1,044	103
ESC LHIN	39	4,124	101	39	4,296	103	36	4,201	99
Ontario	637	70,896	104	637	74,591	106	NA	NA	NA

Source: PDST for 2003/04 and 2004/05 data

PDST has not been updated for 2005/06 – information for this time period is based upon information from the CCACs in Windsor Essex, Chatham-Kent and Sarnia/Lambton 2006.

Observations

The number of Long Term Care beds per 1,000 population over the age of 75 has decreased in 2005/06, a reflection of both the increased proportion of residents in this age group, and the reduction of LTC beds in Essex County. This decrease can impact on the ability of hospitals to appropriately place patients and leads to lengthy waiting lists in some areas across the ESC LHIN.

- The number of Long Term Care beds has remained relatively constant for Chatham Kent over the past three years
- The reduction in beds per 1000 for Chatham Kent is due to the increase in population in the 75+ age group
- This analysis notes that in 2006, with the opening of Riverview Gardens in Chatham Kent, residents of Thamesview Lodge and Victoria Home were relocated. Therefore in 2006/07, there are seven facilities in Chatham Kent with the same capacity (847 beds)
- There has been fluctuation in the number of Long Term Care beds in Essex County over the last three years with a decrease of 100 beds in 2005/06, resulting from facility closures (and bed reductions) and no additional beds reallocated into the county
- The significant reduction in beds/1000 population aged 75+ therefore reflects the reduced capacity as well as the increased population within this age group
- The reduced bed capacity impacts the ability of Essex hospitals to discharge patients requiring LTC in a timely fashion, and is reflected in the lengthy waiting lists for placement
- The number of Long Term Care beds in Lambton has remained constant over the three year period
- The reduction in beds/1000 population aged 75+ is reflective of the increased population within this age group

3.4 Health Human Resources

Definition

- Number of active physicians (GPs and specialists) per 100,000 area resident population
- Number of registered nurses, registered practical nurses and registered nurses extended class (nurse practitioners) by Type and Working Status, Practice Sector, Dimension of Practice, Age Grouping - 2005, Trending of Age Groups for Southwest Region 2000-2005

Significance/Uses

- Indicator of health care human resources available to serve an area resident population
- Composite indicator of health care capacity in an area
- Useful for human resources planning and development of special incentive programs to provide health care human resources for under-serviced districts

Limitations

- Data on human resources varies by type of employment and by the agency
- Does not measure under employment or unemployment among health care providers
- Some resources are used to serve non-resident populations
- Some members may work in more than one LHIN area
- Some data may include inactive members
- Nursing data is based on self-reports to the College of Nurses of Ontario with payment of dues, therefore the numbers may not capture all qualified nurses in the district
- Changes in the way that data is collected may change over time and will affect the consistency and comparability of the data
- Does not adjust for full time equivalency and therefore does not provide information on work intensity

Source

- "Physicians in Ontario" 2002-2004, Ontario Physician Human Resources Data Centre; College of Nurses of Ontario, MOHLTC

Active Physicians and Physicians/100,000 Population, by County, ESC LHIN and Ontario 2002 – 2004

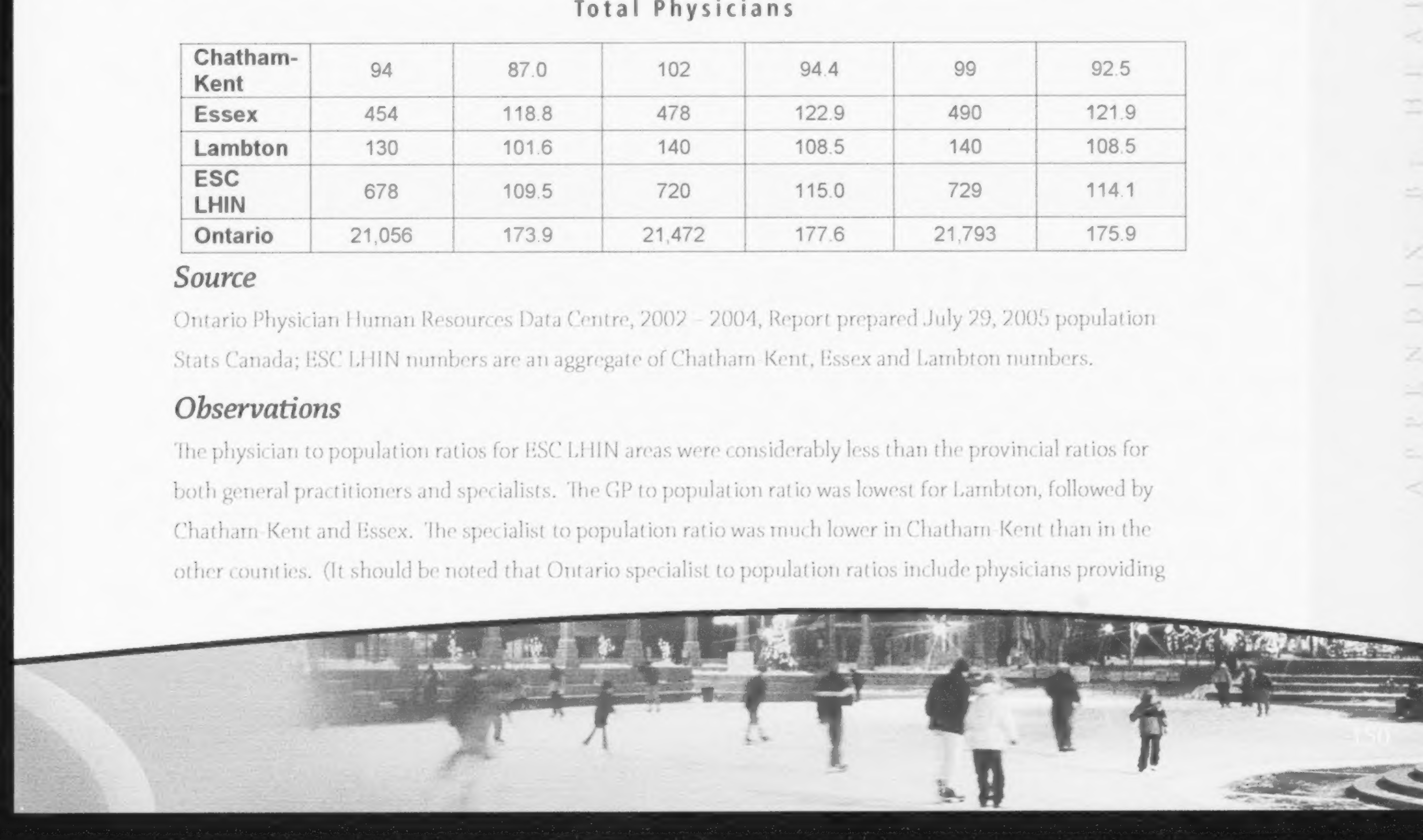
	2002		2003		2004	
Location	**Active Physicians**	**Physicians/ 100,000 Population**	**Active Physicians**	**Physicians/ 100,000 Population**	**Active Physicians**	**Physicians/ 100,000 Population**
		Non-Specialists				
Chatham-Kent	56	51.8	61	56.5	61	57.0
Essex	223	58.4	242	62.2	243	60.4
Lambton	65	50.8	70	54.3	69	53.5
ESC LHIN	344	55.6	373	59.6	373	58.4
Ontario	10,056	83.0	10,287	84.9	10,439	84.3
		Specialists				
Chatham-Kent	38	35.2	41	37.9	38	35.5
Essex	231	60.5	236	60.8	247	61.4
Lambton	65	50.8	70	54.3	71	55.0
ESC LHIN	334	54.0	347	55.4	356	55.7
Ontario	11,000	90.8	11,185	92.3	11.354	91.6
		Total Physicians				
Chatham-Kent	94	87.0	102	94.4	99	92.5
Essex	454	118.8	478	122.9	490	121.9
Lambton	130	101.6	140	108.5	140	108.5
ESC LHIN	678	109.5	720	115.0	729	114.1
Ontario	21,056	173.9	21,472	177.6	21,793	175.9

Source

Ontario Physician Human Resources Data Centre, 2002 – 2004, Report prepared July 29, 2005 population Stats Canada; ESC LHIN numbers are an aggregate of Chatham-Kent, Essex and Lambton numbers.

Observations

The physician to population ratios for ESC LHIN areas were considerably less than the provincial ratios for both general practitioners and specialists. The GP to population ratio was lowest for Lambton, followed by Chatham-Kent and Essex. The specialist to population ratio was much lower in Chatham-Kent than in the other counties. (It should be noted that Ontario specialist to population ratios include physicians providing



care in specialized regional and provincial programs which serve residents of ESC LHIN and therefore it is difficult to estimate additional specialists required strictly by comparing these ratios).

- In Chatham-Kent for 2004, the GP ratio per 100,000 population was 32% lower than Ontario, and the specialist ratio was 62% lower than Ontario
- In Essex for 2004, the GP ratio per 100,000 population was 28% lower than Ontario, and the specialist ratio was 33% lower than Ontario
- In Lambton for 2004, the GP ratio per 100,000 population was 36% lower than the province, and the specialist ratio was 40% lower than Ontario

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G.P. Designated Under serviced Areas, April/May/June 2006

		Complement	Vacancy	% Shortage
Chatham-Kent				
	County	69	20	29%
Essex County				
	Amherstburg	13	7	54%
	Essex	11	8	73%
	Harrow	6	5	83%
	Kingsville	26	9	35%
	Lakeshore	13	10	77%
	Windsor	164	37	23%
Lambton				
	Forest	14	4	29%
	Sarnia	67	24	36%
ESC LHIN		383	124	32%

GP Supply Status

	Shortage	% Short
Chatham-Kent	20	29%
Essex	76	33%
Lambton	28	35%
ESC LHIN	124	32%

Source: MOHLTC website, Underserviced Area Program, September 2006

The tables above represent the most recent data (April – June 2006) for designated under serviced areas for General/Family Practitioners.

Observations

- Overall, ESC LHIN is under serviced by 32% compared to Ontario
- Essex is short 76 physicians, while Lambton is short 28 and Chatham-Kent 20

Active specialists by Type, Total Number and Number/100,000 Population, by County, ESC LHIN and Ontario 2004

Specialty	Chatham-Kent		Essex		Lambton		ESC LHIN		Ontario	
	#	# per 100,000 Pop	#	# per 100,000 Pop	#		#	# per 100,000 Pop	#	# per 100,000 Pop
Internal Medicine	7	6.4	63	15.7	14	10.6	84	13.0	2,858	23.1
General Internal Medicine	5	4.5	14	3.5	5	3.8	24	3.7	586	4.7
Cardiology	0	0	7	1.7	3	2.3	10	1.6	479	3.9
Clinical Immunology	0	0	4	1.0	0	0	4	0.6	63	0.5
Dermatology	0	0	5	1.2	1	0.8	6	0.93	174	1.4
Endocrinology	1	0.9	4	1.0	0	0	5	0.78	149	1.2
Gastroenterology	1	0.9	4	1.0	1	0.8	6	0.93	222	1.8
Hematology	0	0	1	0.3	0	0	1	0.2	132	1.1
Infectious diseases	0	0	1	0.3	0	0	1	0.2	75	0.6
Medical Oncology	0	0	7	1.7	1	0.8	8	1.2	147	1.2
Nephrology	0	0	3	0.8	0	0	3	0.5	152	1.2
Neurology	0	0	6	1.5	1	0.8	7	1.1	240	1.9
Respirology	0	0	6	1.5	1	0.8	7	1.1	203	1.6
Rheumatology	0	0	1	0.3	1	0.8	2	0.3	149	1.2
Geriatric Medicine	0	0	0	0	0	0	0	0	87	0.7
Pediatrics	3	2.7	16	4.0	4	3	23	3.6	936	7.6
Surgery	17	15.5	81	20.2	24	18.2	122	18.9	2,905	23.5
General Surgery	6	5.5	16	4.0	5	3.8	27	4.2	539	4.4
Cardiothoracic	0	0	1	0.3	2	1.5	3	0.5	83	0.7
Neurosurgery	0	0	4	1.0	0	0	4	0.6	68	0.6
Obs/Gyn	4	3.6	19	4.7	6	4.5	29	4.5	640	5.2
Ophthalmology	3	2.7	9	2.2	2	1.5	14	2.2	411	3.3
Orthopaedic Surgery	1	0.9	8	2.0	4	3.0	13	2.0	420	3.4
Otolaryngology	1	0.9	7	1.7	2	1.5	10	1.6	222	1.8
Plastic Surgery	0	0	5	1.2	0	0	5	0.8	180	1.5
Thoracic Surgery	0	0	1	0.3	0	0	1	0.2	32	0.3
Urology	2	1.8	7	1.7	3	2.3	12	1.9	225	1.8
Vascular Surgery	0	0	4	1.0	0	0	4	0.6	69	0.6
Other	0	0	0	0	0	0	0	0	6	-

Specialists by Type, Total Number and Number/100,000 Population, by County, ESC LHIN and Ontario 2004 (continued)

Specialty	Chatham-Kent		Essex		Lambton		ESC LHIN		Ontario	
	#	# per 100,000 Pop	#	# per 100,000 Pop	#	# per 100,000 Pop	#	# per 100,000 Pop	#	# per 100,000 Pop
Laboratory Medicine	1	0.9	9	2.2	3	2.3	13	2.0	449	3.6
General Pathology	0	0	4	1.0	2	1.5	6	0.9	115	0.9
Anatomical Pathology	1	0.9	5	1.2	1	0.8	7	1.1	246	2.0
Total Pathology	1	0.9	9	2.2	3	2.3	13	2.0	361	2.9
Other	0	0	0	0	0	0	0	0	88	-
Other Specialties	10	9.1	78	19.4	26	19.7	114	17.7	4,206	33.9
Anesthesia	3	2.7	21	5.2	7	5.3	31	4.8	942	7.6
Community Public Health	0	0	2	0.5	1	0.8	3	0.5	92	0.7
Diagnostic Radiology	3	2.7	22	5.5	7	5.3	32	5.0	785	6.3
Nuclear Medicine	0	0	5	1.2	0	0	5	0.2	76	0.6
Physical Medicine & Rehab	0	0	3	0.8	0	0	3	0.5	155	1.3
Psychiatry	4	3.6	20	5.0	10	7.6	34	5.3	1,783	14.4
Radiation Oncology	0	0	5	1.2	1	0.8	6	0.9	146	1.2
Other	0	0	0	0	0	0	0	0	227	-
Total Specialists	38	35.5	247	61.4	71	55.0	356	55.7	11,354	91.6

Source: Ontario Physicians Human Resources Data Centre, Active Physician registry December 2004, Report prepared July 29, 2005

Observations

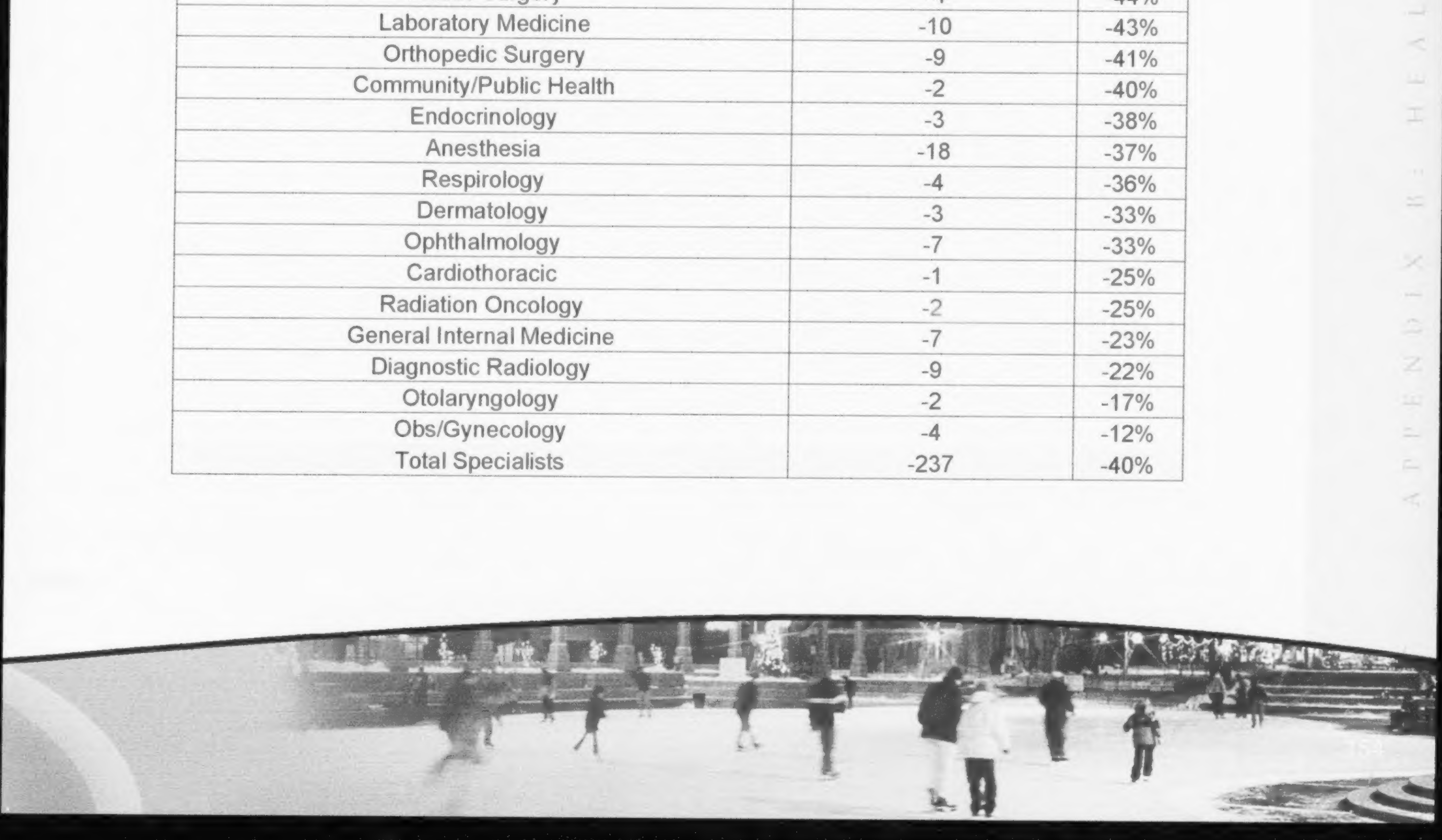
- In all major specialties, the number of physicians per 100,000 population is well below the provincial average

The table below summarizes the shortages in the ESC LHIN for specialists based upon the Ontario per capita supply. A large caution should be noted for the "Shortage" figures. These are simple numbers based on provincial rates that include teaching, research and administrative as well as provider physicians. One cannot simply state that ESC LHIN is short by the number of physicians shown below. The numbers are here to give an indication of general magnitude of shortage, not a planning target.

ESC LHIN Specialist Physician Status, 2004*

Shortages based on Ontario per capita supply

Specialty	Shortage (rounded)	% Short
Geriatric Medicine	-5	-100%
Hematology	-6	-86%
Infectious diseases	-3	-75%
Rheumatology	-6	-75%
Psychiatry	-59	-63%
Nephrology	-5	-63%
Physical Medicine & Rehab	-5	-63%
Cardiology	-15	-60%
Pediatrics	-26	-53%
Gastroenterology	-6	-50%
Thoracic Surgery	-1	-50%
Anatomical Pathology	-6	-46%
Neurology	-6	-46%
Plastic Surgery	-4	-44%
Laboratory Medicine	-10	-43%
Orthopedic Surgery	-9	-41%
Community/Public Health	-2	-40%
Endocrinology	-3	-38%
Anesthesia	-18	-37%
Respirology	-4	-36%
Dermatology	-3	-33%
Ophthalmology	-7	-33%
Cardiothoracic	-1	-25%
Radiation Oncology	-2	-25%
General Internal Medicine	-7	-23%
Diagnostic Radiology	-9	-22%
Otolaryngology	-2	-17%
Obs/Gynecology	-4	-12%
Total Specialists	-237	-40%



Observations

- Based on ESC LHIN population and the Ontario supply by speciality, ESC LHIN is under supplied (short) by 237 specialist physicians or 40% of the current ESC LHIN supply
- The greatest shortage is in geriatric medicine. There are none, but the per capita "share" would be five
- The largest numerical shortage is psychiatrists. ESC LHIN is short 59 of these specialists
- The second largest numerical shortage is paediatricians at 26 followed by anaesthetists at 18

Age Groupings of General Practitioners and Specialists by County, ESC LHIN and Ontario 2004

General Practitioners

	25-39		40-54		55-64		65-85		Total
Location	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**
Chatham-Kent	8	13.1	28	45.9	15	24.6	10	16.4	**61**
Essex	64	26.3	103	42.4	51	21.0	25	10.3	**243**
Lambton	13	18.8	29	42.0	21	30.4	6	8.7	**69**
ESC LHIN	85	22.8	160	42.9	87	23.3	41	11.0	**373**
Ontario	2,436	23.3	4,875	46.7	2,173	20.8	955	9.1	**10,439**

Specialists

	25-39		40-54		55-64		65-85		Total
Location	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**
Chatham-Kent	4	10.5	16	42.1	11	28.9	7	18.4	**38**
Essex	43	17.4	113	45.7	46	18.6	45	18.2	**247**
Lambton	3	4.2	37	52.1	15	21.1	16	22.5	**71**
ESC LHIN	50	14.0	166	46.6	72	20.2	68	19.1	**356**
Ontario	2,304	20.3	5,208	45.9	2,398	21.1	1,444	12.7	**11,354**

Source

Ontario Physician Human Resources Data Centre, 2004, Report prepared July 29, 2006, ESC LHIN numbers are an aggregate of Chatham Kent, Essex and Lambton numbers.

Observations

Generally, the physician workforce in the ESC LHIN is older compared with Ontario. Across the ESC LHIN, as well as Ontario, the largest proportion of GPs and specialists are in the 40 – 54 age bracket. 34% of general practitioners in ESC LHIN are over the age of 55, compared with 30% for Ontario.11% are over the age of 65 in ESC LHIN compared with 9% in Ontario. 39% of specialists are over the age of 55 in ESC LHIN compared with 34% for Ontario. 19% are over the age of 65 in ESC LHIN compared with 13% in Ontario.

- 16% of general practitioners in Chatham-Kent in 2004 were over the age of 65, compared with 9% for the province
- 41% of general practitioners were over the age of 55 compared with 30% for Ontario
- Only 13% were aged 25 – 39 compared to the provincial rate of 23%
- 47% of specialists were over the age of 55, compared with 34% for Ontario
- 18% of specialists were over the age of 65, compared to 13% for the province
- Only 10% of specialists were between the ages of 25 – 39 compared with 20% for Ontario
- Essex ratios were similar to the province for GPs in the 55+ age bracket, with 21% between 55 – 64 and 10% over 65
- 26% of Essex GPs were between the ages of 25 – 39, higher than the Ontario rate and highest in ESC LHIN
- Approximately 37% of Essex specialists are over the age of 55, compared to 34% for Ontario; 18% of these are over the age of 65
- 17% of specialists were between the ages of 25 – 39, the highest by far in the ESC LHIN, but still lower than Ontario at 20%
- 39% of Lambton GPs are over the age of 55, the majority of these in the 55 – 64 age group (30%)
- 19% of GPs are in the 25 – 39 age group, compared to the Ontario rate of 23%
- 23% of specialists in Lambton are over the age of 65, compared to 13% for Ontario
- Only 4% of specialists are between the ages of 25 – 39

Health Human Resource Supply for ESC LHIN and Ontario 2005/2006

Category	# Members		# Members per	
			100,000 Population	
	ESC LHIN	Ontario	ESC LHIN	Ontario
Pharmacists	437	10,351	67.6	82.5
Occupational Therapists	138	4,010	21.4	32.0
Physiotherapists	239	6,080	37.0	48.5
Dietitians	85	2,609	13.2	20.8
Midwifery	8	334	1.2	2.7
Medical Laboratory Technologists	N/A	7.738	N/A	61.7
Medical Radiation Technologists	N/A	5,939	N/A	47.4
Speech Language Pathologists	N/A	2.385	N/A	19.0
Registered Nurses	4,252	89,050	657.8	710.1
Registered Nurses - Extended	46	583	7.1	4.7
Registered Practical Nurses	1,385	24,480	214.3	195.2

Source

MOHLTC August 2006

Observations

- Although the limitations of the data are acknowledged, ESC LHIN has fewer health care professionals per 100,000 population than Ontario in all categories, with the exception of Extended Class Registered Nurses and Registered Practical Nurses
- Efforts should be made in future years to obtain standardized Health Human Resource data for planning purposes
- Further breakdown of nursing resources by planning area within the ESC LHIN are shown in the following tables

Nursing Resources within ESC LHIN 2005

Nurses Employed in Erie St. Clair by Type and Working Status 2005

Working Status	RN General Class (Registered Nurse)		RPN (Registered Practical Nurse)		RNEC (Registered Nurse Extended Class)	
	#	%	#	%	#	%
			Chatham-Kent			
Full Time	466	58.4	146	53.3	11	100
Part Time	267	33.5	106	38.7	0	0
Casual	65	8.1	22	8.0	0	0
Total	**798**	**100**	**274**	**100**	**11**	**100**
			Essex			
Full Time	1,538	61.1	409	52.2	**	**
Part Time	856	34.0	343	43.8	*	*
Casual	124	4.9	31	4.0	0	0
Total	**2,518**	**100**	**783**	**100**	**22**	**100**
			Lambton			
Full Time	444	47.4	158	48.2	8	61.5
Part Time	370	39.5	149	45.4	5	38.5
Casual	122	13.0	21	6.4	0	0
Total	**936**	**100**	**328**	**100**	**13**	**100**
			ESC LHIN			
Full Time	2,448	57.6	713	51.5	**	**
Part Time	1,493	35.1	598	43.2	*	*
Casual	311	7.3	74	5.3	0	0
Total	**4,252**	**100**	**1,385**	**100**	**46**	**100**
			Ontario			
Full Time	53,355	59.9	13,460	55.0	449	75.6
Part Time	27,799	31.2	8,754	35.8	130	21.9
Casual	7,900	8.9	2,268	9.3	15	2.5
Total	**89,054**	**100**	**24,482**	**100**	**594**	**100**

Source

College of Nurses of Ontario (CNO) September 2006. Notes Re: Data Suppression for all Nursing Resource

Tables "The College is committed to protecting the privacy and confidentiality of its members. Cell counts between one and four have been suppressed in this report, and the value has been replaced by an asterisk (*). In cases where this is done, the next smallest cell count is also suppressed to ensure that the values cannot be derived. This value is replaced with two asterisks (**), so that readers know the value was not suppressed due to a low cell count. When there are multiple values between one and four in a table, only those values are suppressed. An exception is made when the low cell count is in the "Not Specified" category. Because this category does not provide any information, it does not need to be suppressed to protect members' privacy," CNO.

Nurses Employed in Erie St. Clair by Type and Practice Sector, 2005

Practice Sector	RN General Class		RPN		RNEC	
	#	%	#	%	#	%
Chatham-Kent						
Hospital	392	49.1	116	42.3	**	**
Long Term Care	126	15.8	108	39.4	0	0
Community	179	22.4	**	**	*	*
Other	82	10.3	*	*	0	0
Not Specified	19	2.4	18	6.6	0	0
Total	**798**	**100**	**274**	**100**	**11**	**100**
Essex						
Hospital	1,506	59.8	292	37.3	**	**
Long Term Care	228	9.1	288	36.8	0	0
Community	520	20.7	148	18.9	12	54.5
Other	198	7.9	13	1.7	*	*
Not Specified	66	2.6	42	5.4	1	4.5
Total	**2,518**	**100**	**783**	**100**	**22**	**100**
Lambton						
Hospital	548	58.5	157	47.9	0	0
Long Term Care	117	12.5	116	35.4	*	*
Community	193	20.6	40	12.2	**	**
Other	55	5.9	2	0.6	0	0
Not Specified	23	2.5	13	4.0	0	0
Total	**936**	**100**	**328**	**100**	**13**	**100**

ESC LHIN

Hospital	2,446	57.5	565	40.8	**	**
Long Term Care	471	11.1	512	37.0	*	*
Community	892	21.0	**	**	*	*
Other	335	7.9	*	*	*	*
Not Specified	108	2.5	73	5.3	1	2.2
Total	**4,252**	**100**	**1,385**	**100**	**46**	**100**

Ontario

Hospital	56,563	63.5	11,228	45.9	122	20.5
Long Term Care	7,960	8.9	8,147	33.3	19	3.2
Community	15,843	17.8	3,119	12.7	366	61.6
Other	6,030	6.8	562	2.3	53	8.9
Not Specified	2,658	3.0	1,426	5.8	34	5.7
Total	**89,054**	**100**	**24,482**	**100**	**594**	**100**

Source: CNO, September 2006

Nurses Employed in Erie St. Clair by Type and Dimension of Practice, 2005

Dimension of Practice	RN General Class		RPN		RNEC	
	#	%	#	%	#	%
Chatham-Kent						
Direct Practice	669	83.8	261	95.3	11	100
Education	23	2.9	0	0	0	0
Administration	83	10.4	5	1.8	0	0
Research	0	0	0	0	0	0
Other	0	0	0	0	0	0
Not Specified	23	2.9	8	2.9	0	0
Total	**798**	**100**	**274**	**100**	**11**	**100**
Essex						
Direct Practice	2,158	85.7	736	94.0	17	77.3
Education	113	4.5	*	*	*	*
Administration	152	6.0	**	**	*	*
Research	8	0.3	0	0	0	0
Other	0	0.0	0	0	0	0
Not Specified	87	3.5	32	4.1	1	4.5
Total	**2,518**	**100**	**783**	**100**	**22**	**100**
Lambton						
Direct Practice	819	87.5	311	94.8	12	92.3
Education	27	2.9	*	*	0	0
Administration	66	7.1	**	**	0	0
Research	2	0.2	0	0	0	0
Other	0	0	0	0	0	0
Not Specified	22	2.4	9	2.7	1	0.7
Total	**936**	**100**	**328**	**100**	**13**	**100**
ESC LHIN						
Direct Practice	3,646	85.8	1,308	94.4	40	87.0
Education	163	3.8	*	*	*	*
Administration	301	7.1	**	**	*	*
Research	10	0.2	0	0	0	0
Other	0	0	0	0	0	0
Not Specified	132	3.1	49	3.5	2	4.3
Total	**4,252**	**100**	**1,385**	**100**	**46**	**100**
Ontario						
Direct Practice	76,574	86.0	22,803	93.1	538	90.6
Education	2,770	3.1	80	0.3	**	**
Administration	6,616	7.4	471	1.9	19	3.2
Research	600	0.7	25	0.1	*	*
Other						
Not Specified	2,494	2.8	1,103	4.5	17	2.9
Total	**89,054**	**100**	**24,482**	**100**	**594**	**100**

Source: CNO, September 2006

Comparison of Age Groupings, ESC LHIN and Ontario, 2005 – RN General Class and RPN's

ESC LHIN				
Age Groups	RN General Class		RPN	
	#	%	#	%
18 – 24	83	2.0	**	**
25 – 29	340	8.0	102	7.4
30 – 34	474	11.2	158	11.4
35 – 39	448	10.5	142	10.3
40 – 44	608	14.3	191	13.8
45 – 49	569	13.4	259	18.7
50 – 54	835	19.6	268	19.4
55 – 59	590	13.9	169	12.2
50 – 64	229	5.4	47	3.4
65+	76	1.8	*	*
Not Specified	0	0	2	0.1
Total	**4,252**	**100**	**1,385**	**100**

Ontario

Age Groups	RN General Class		RPN	
	#	%	#	%
18 – 24	1,801	2.2	635	2.6
25 – 29	10,246	12.5	1,494	6.1
30 – 34	11,129	13.6	2,293	9.4
35 – 39	14,086	17.2	2,767	11.3
40 – 44	14,427	17.6	3,651	14.9
45 – 49	12,480	15.2	4,139	16.9
50 – 54	8,771	10.7	4,467	18.3
55 – 59	5,512	6.7	3,344	13.7
50 – 64	2,835	3.5	1,381	5.6
65+	806	1.0	309	1.3
Not Specified	12	.01	2	.01
Total	**82,105**	**100**	**24,482**	**100**

Source: CNO, September 2006

Age analysis not performed for RNEC (Extended Class Nurses) due to small cell counts and suppressed numbers.

Nurses Employed in Erie St. Clair by Type and Age Grouping, 2005 – RN General Class and RPNs

Chatham-Kent				
Age Groups	RN General Class		RPN	
	#	%	#	%
18 – 24	7	0.9	11	4.0
25 – 29	45	5.6	30	10.9
30 – 34	73	9.1	37	13.5
35 – 39	91	11.4	23	8.4
40 – 44	129	16.2	30	10.9
45 – 49	118	14.8	57	20.8
50 – 54	155	19.4	49	17.9
55 – 59	119	14.9	23	8.4
50 – 64	48	6.0	13	4.7
65+	13	1.6	0	0
Not Specified	0	0	1	0.4
Total	**798**	**100**	**274**	**100**

Essex

Essex				
Age Groups	RN General Class		RPN	
	#	%	#	%
18 – 24	57	2.3	19	2.4
25 – 29	226	9.0	56	7.2
30 – 34	307	12.2	91	11.6
35 – 39	265	10.5	89	11.4
40 – 44	349	13.9	116	14.8
45 – 49	327	13.0	138	17.6
50 – 54	478	19.0	144	18.4
55 – 59	342	13.6	103	13.2
50 – 64	116	4.6	20	2.6
65+	51	2.0	6	0.8
Not Specified	0	0	1	0.1
Total	**2,518**	**100**	**783**	**100**

Lambton

Age Groups	RN General Class		RPN	
	#	%	#	%
18 – 24	19	2.0	**	**
25 – 29	69	7.4	16	4.9
30 – 34	94	10.0	30	9.1
35 – 39	92	9.8	30	9.1
40 – 44	130	13.9	45	13.7
45 – 49	124	13.2	64	19.5
50 – 54	202	21.6	75	22.9
55 – 59	129	13.8	43	13.1
50 – 64	65	6.9	14	4.3
65+	12	1.3	*	*
Not Specified	0	0	0	0
Total	**936**	**100**	**328**	**100**

Observations

- In 2005, there were 5,683 nurses (all type) employed in ESC LHIN – 4,252 RNs General Class, 1,385 RPNs, and 46 RNEC (nurse practitioners)
- Over half of the RNs and RPNs in ESC LHIN are employed full time, with some variation as shown in the individual planning areas
- Almost 70% of RNs in ESC LHIN are employed in institutions (58% in hospitals and 11% in Long Term Care facilities) and 21% in community nursing. Almost 80% of RPNs are employed in institutions. These rates are similar to Ontario
- 86% of RNs and 94% of RPN's are employed in direct practice, similar to the province. 7% of RNs work in administration and 4% in education, similar to the province
- 32% of the RNs in ESC LHIN are under the age of 40, compared with 45% for Ontario, while the proportion of RPNs in this age group is 29%, similar to Ontario
- 47% of the RNs in ESC LHIN are between the ages of 40 – 54, compared with 43% for Ontario, while 52% of RPNs are in this age group, similar to Ontario
- The proportion of nurses over the age of 55 is 21%, compared with 11% for Ontario, while the proportion of RPNs over 55 is approximately 15% compared with 20% for Ontario
- Very little analysis could be done for the nurse practitioners (RNEC) due to small numbers; however the majority of extended class nurses are employed in direct practice, similar to the province

ESC LHIN data is not available for the years prior to 2005; therefore the following data for Southwest Ontario region of which ESC LHIN is part is used to show trending by broad age groupings from 2000 - 2005.

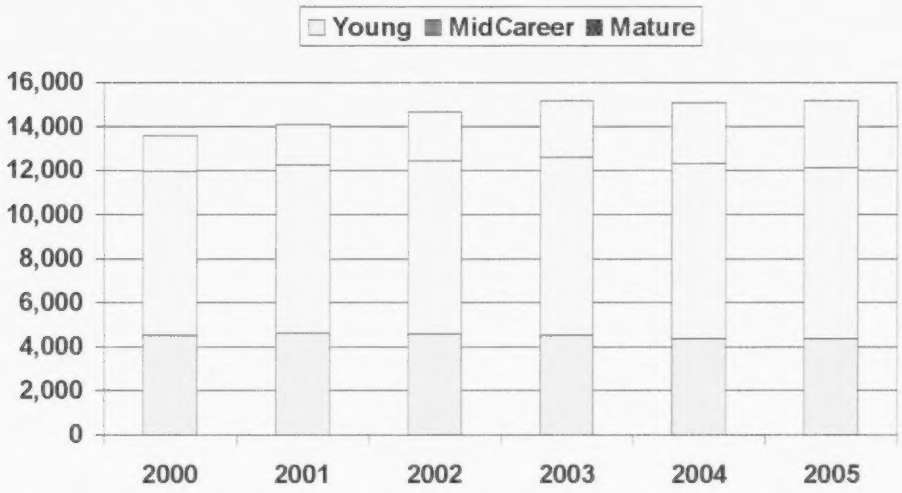
All Nursing Types Employed in Nursing*

CNO Southwest Ontario Region

Year	Young	Mid-Career	Mature	Total
2000	4,533	7,425	1,610	13,568
2001	4,616	7,658	1,812	14,086
2002	4,558	7,921	2,216	14,695
2003	4,518	8,077	2,579	15,174
2004	4,392	7,926	2,760	15,078
2005	4,371	7,748	3,052	15,171

*CNO Southwest Ontario Region

Employed Nurses in CNO Southwest Ontario



Observations

- The total number of nurses employed in the CNO Southwest Ontario Region increased from 2000 to 2003, where it has stabilized at about 15,200 persons
- The number of young nurses (those under 40) peaked in 2001 and since then continues to decline since then
- The number of mid-career nurses (40 to 54) rose until 2003 and then began to decline
- The number of mature nurses (those over 55) has increased significantly since 2001
- The number of worked nursing hours is unavailable

3.5 Health Care Expenditures by Sector

Definition

- Amount and proportion of MOHLTC funded expenditures allocated by health care sector, during a given fiscal year, base funding only
- Funded programs include Hospitals; CCAC, Long Term Care (LTC) Facilities, Community Support Services; Children's Treatment Centres (CTC), Mental Health and Addictions, Homes for Special Care

Significance/Uses

- Indicator of level of funding by the major health care sectors
- Indicator of distribution of funding for health care to an area resident population
- Useful in planning for different health care sectors

Limitations

- The distribution of health care funding is based on the geographical location of the institution or service provider
- Data reflects funding provided by the MOHLTC Southwest Regional Office, which does not include all MOHLTC funded programs. The sectors have changed over time, therefore information for some sectors is only available for one year
- Data was provided by the MOHLTC Southwest Regional Office, therefore provincial estimates are not available
- The funding estimates should not be interpreted as any comment on the relative adequacy of funding or efficiency of resource use

Source

- MOHLTC Southwest Regional Office

Health Care Expenditures/Investments by Sector 2005/2006
Base Funding for MOHLTC-Funded Services in ESC LHIN 2005/2006 ($)

Program	Chatham-Kent	Essex	Lambton	ESC LHIN	% of Total Budget
ABI	189,576	766,117	0	955,693	0.1%
ALSSH	891,774	2,610,702	1,370,029	4,872,505	0.6%
CCAC	16,324,270	46,389,052	17,650,256	80,363,578	10.0%
CHC	0	6,556,749	5,909,218	12,465,967	1.6%
Community Mental Health	4,879,669	12,593,628	4,686,317	22,159,614	2.8%
CSS*	2,010,609	6,099,113	3,094,089	11,203,811	1.4%
LTC	29,032,459	83,739,673	35,785,282	148,557,414	18.6%
Hospitals	88,364,700	295,585,400	130,191,600	514,141,700	64.2%
Substance Abuse	1,753,858	3,245,623	507,682	5,507,163	0.7%
Problem Gambling	78,268	667,139	86,296	831,703	0.1%
*CTC***	*2,319,429*	*7,937,448*	*4,467,315*	*14,724,192*	**
Total	**143,525,183**	**458,253,196**	**199,280,769**	**801,059,148**	**100%**

Source

Revised MOHLTC Regional Office, September 2006

The table above represents the base funding allocations for MOHLTC-funded services in ESC for 2005/06.

*CSS does not include Homemakers and Nurses, Elderly Persons Centres or PSW training.

**As previously discussed, Children's Treatment Centre funding is partially provided by other ministries in addition to MOHLTC and is discussed further in Section 2.

Observations

- Across ESC, 64% of MOHLTC funding is invested in the operation of hospitals, almost 19% to Long Term Care Homes, 10% to CCACs and the remainder split among other programs as indicated

POPULATION CHARACTERISTICS

SECTION 4

4.1 Population Structure by Age and Sex

Definition

- Population by age group, growth rates and dependency ratios

Significance/Uses

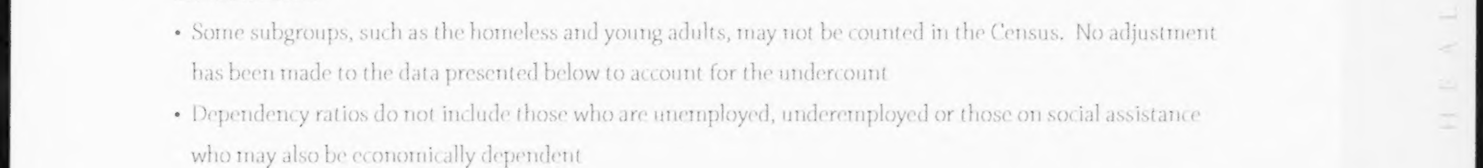
- Shows the population structure of the population at points in time
- Composition is affected by net migration, fertility and aging
- The population data can be combined with health/illness/utilization data to estimate projected volumes
- Population, age, and sex distribution is used to calculate age/sex-standardized rates to compare health data across time and place
- Dependency ratios reflect the number of people in economically dependent groups (age 0-14 and 65+) divided by the number of persons 15 to 64 years-old

Limitations

- Some subgroups, such as the homeless and young adults, may not be counted in the Census. No adjustment has been made to the data presented below to account for the undercount
- Dependency ratios do not include those who are unemployed, underemployed or those on social assistance who may also be economically dependent

Source

- 2001 Census, Statistics Canada, Ministry of Finance Population Projections 2005-2031



Population by 5 year Age Cohorts by Area, ESC LHIN and Ontario

2006 Population Estimates

	CHATHAM-KENT		ESSEX		LAMBTON		ESC LHIN		Ontario	
Age Group	Popn	% of PA	Popn	% of PA	Popn	% of PA	Popn	% of PA	Popn	% of PA
0-4	5,410	5.0%	22,530	5.5%	5,730	4.3%	33,670	5.2%	670,750	5.3%
5-9	6,360	5.8%	25,990	6.3%	7,160	5.4%	39,510	6.1%	756,270	6.0%
10-14	7,420	6.8%	27,550	6.7%	8,680	6.6%	43,650	6.7%	837,120	6.6%
15-19	8,000	7.3%	27,910	6.8%	9,570	7.2%	45,480	7.0%	850,230	6.7%
20-24	7,830	7.2%	28,930	7.1%	9,370	7.1%	46,130	7.1%	871,330	6.9%
25-29	5,890	5.4%	28,350	6.9%	7,440	5.6%	41,680	6.4%	852,340	6.7%
30-34	6,090	5.6%	29,240	7.1%	6,960	5.3%	42,290	6.5%	894,410	7.0%
35-39	6,730	6.2%	31,770	7.7%	7,920	6.0%	46,420	7.1%	964,220	7.6%
40-44	8,610	7.9%	34,420	8.4%	9,740	7.4%	52,770	8.1%	1,086,270	8.6%
45-49	9,130	8.4%	32,080	7.8%	10,790	8.2%	52,000	8.0%	1,023,670	8.1%
50-54	8,040	7.4%	27,290	6.7%	10,300	7.8%	45,630	7.0%	881,460	6.9%
55-59	7,170	6.6%	24,180	5.9%	9,430	7.1%	40,780	6.3%	779,700	6.1%
60-64	5,500	5.1%	18,190	4.4%	7,620	5.8%	31,310	4.8%	585,490	4.6%
65-69	4,650	4.3%	14,300	3.5%	5,970	4.5%	24,920	3.8%	465,920	3.7%
70-74	3,840	3.5%	12,300	3.0%	5,230	4.0%	21,370	3.3%	400,660	3.2%
75-79	3,460	3.2%	11,010	2.7%	4,520	3.4%	18,990	2.9%	339,240	2.7%
80-84	2,610	2.4%	8,150	2.0%	3,360	2.5%	14,120	2.2%	247,820	2.0%
85-89	1,440	1.3%	3,970	1.0%	1,640	1.2%	7,050	1.1%	126,730	1.0%
90+	710	0.7%	1,850	0.5%	780	0.6%	3,340	0.5%	62,580	0.5%
65+	16,710	15%	51,580	13%	21,500	16%	89,790	14%	1,642,950	13%
Total	108,870	100%	409,990	100%	132,200	100%	651,060	100%	12,696,210	100.0%

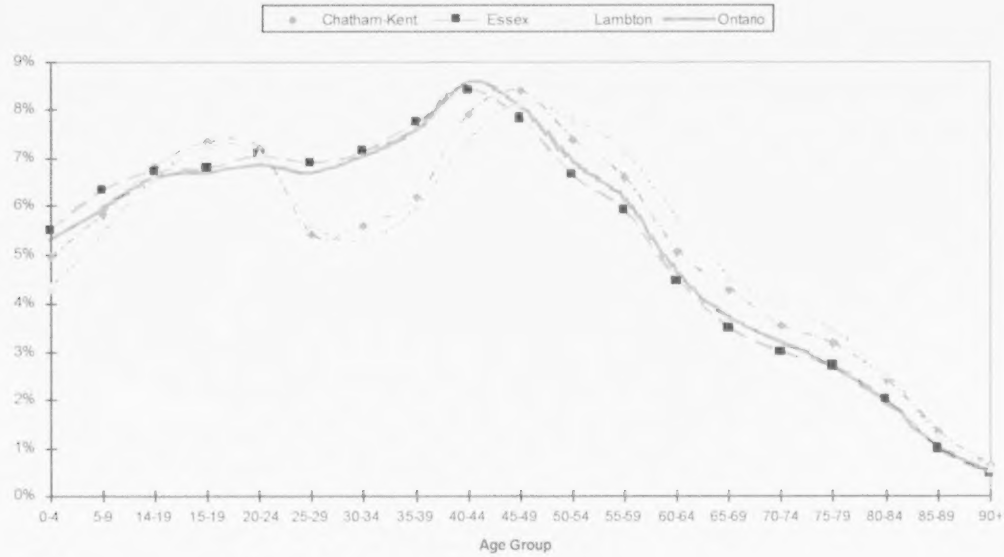
Source: Ministry of Finance population projections published April 2006

Figures may not add to totals due to rounding

Observations

- The population of ESC LHIN is approximately 5.1% of the total population of Ontario with Essex comprising 3.2%, Lambton 1.1% and Chatham-Kent 0.9%
- There is a higher proportion of age 65+ residents in Chatham-Kent and Lambton compared to Essex and Ontario (16% in Lambton, 15% in Chatham-Kent, Essex 12.6% and Ontario 12.9%)
- Essex has a higher proportion of young children (aged 0 – 4 years) than Chatham-Kent and Lambton, and slightly higher than the province
- Overall, for the age group 0 – 14 years, Essex has a higher percentage of the population than Chatham-Kent and Lambton, and slightly higher than the province
- Essex also has a slightly higher proportion of young adults aged 20 – 29 than Chatham-Kent and Lambton and similar to that of the province

Five-year Age Groups, 2006*
as percentage of each PA



Source: Ministry of Finance Population Projections 2005-2031

Observations

- Chatham-Kent and Lambton have fewer 15 - 44 year olds than Ontario, with Essex percentages being very similar to the province
- Chatham-Kent and Lambton have a higher proportion of persons aged 65+ than the province, with Essex being very similar to the province

Growth Rate 2001 - 2006 and Dependency Ratios

Planning Area	2001 Census Population	2006 Population Estimate	Growth Rate 2001-2006	Dependency Ratio* Child (%)	Aged (%)	Total (%)
Chatham-Kent	107,710	108,870	1.1	26.3	22.9	49.2
Essex	374,975	409,990	9.3	26.9	18.3	45.2
Lambton	126,975	132,200	4.1	24.2	24.1	48.3
ESC LHIN	609,660	651,060	6.8	26.3	20.2	46.5
Ontario	11,410,045	12,696,200	11.3	25.8	18.7	44.5

Observations

- For the period of 2001 – 2006, the population of the Erie St. Clair LHIN increased by 6.8%, or an average of 1.4% per year, while the population of the province increased by 11.3%, or an average of 2.3% per year
- Essex continued to show active growth for the period of 9.3% or 1.9% per year
- After showing declining growth for the period of 1996 – 2001, Chatham-Kent showed slight growth of 1.1% for the period of 2001 – 2006 and the Lambton growth rate increased 4.1% for the same period
- Most of the growth in Lambton appeared to be in the 45 – 64 and 20 – 34 age cohorts
- As previously, a larger proportion of Chatham-Kent and Lambton Counties were classified as dependent compared to the province
- Similar ratios of child dependency to the province, with Essex slightly higher reflecting the higher 0-4 proportion of the population
- Chatham-Kent and Lambton had a higher ratio of aged dependency, reflecting the higher percentage of 65+ populations
- These higher dependency ratios, particularly seniors, will have impacts on the need for health care services

4.2 Population Projections

Definition

- Projections of age group populations by county based on fertility, immigration, birth and death rates. Projections are prepared (in 2006) from 2005 to 2031

Significance/Uses

- Predicts future changes in age composition of a population
- Can be used to assess and plan for future services of a community

Limitations

- The underlying assumptions (fertility, immigration, birth and death rates) will not be met. They are however the best estimate of what will happen

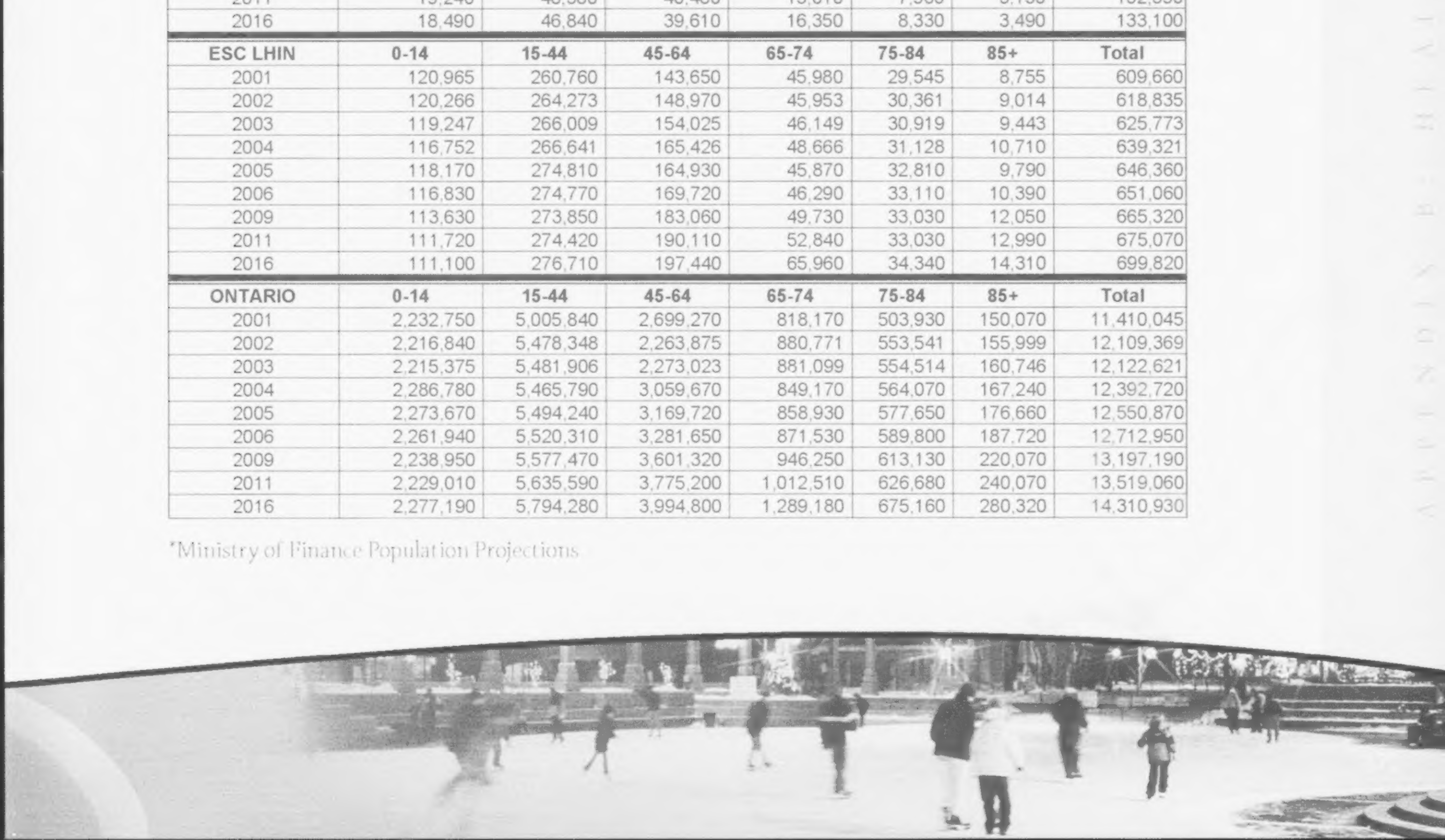
Source

- Ministry of Finance Population Projections 2005-2031

Population Census, Estimates and Projections, 2001 to 2016*

CHATHAM-KENT	0-14	15-44	45-64	65-74	75-84	85+	Total
2001	21,205	44,335	25,965	8,535	5,795	1,885	107,710
2002	20,814	44,221	26,751	8,504	5,869	1,939	108,093
2003	20,393	43,799	27,509	8,528	5,896	1,991	108,099
2004	19,470	42,423	29,025	8,896	5,806	2,095	107,703
2005	19,640	43,880	29,110	8,410	6,090	2,100	109,240
2006	19,190	43,150	29,840	8,490	6,070	2,150	108,870
2009	18,080	41,250	31,590	9,010	5,910	2,270	108,090
2011	17,540	40,390	32,180	9,490	5,830	2,370	107,800
2016	17,090	39,050	31,460	11,470	6,080	2,440	107,570
ESSEX	**0-14**	**15-44**	**45-64**	**65-74**	**75-84**	**85+**	**Total**
2001	75,580	166,715	84,695	26,280	16,775	4,925	374,975
2002	75,760	169,854	88,154	26,315	17,311	5,046	382,441
2003	75,735	172,098	91,488	26,423	17,699	5,312	388,749
2004	75,411	175,094	99,719	27,891	17,908	6,124	402,155
2005	76,300	179,270	98,530	26,420	18,920	5,410	404,840
2006	76,070	180,620	101,740	26,600	19,160	5,820	409,990
2009	75,510	183,270	111,520	28,570	19,210	6,910	424,990
2011	74,940	185,450	117,450	30,340	19,240	7,470	434,880
2016	75,520	190,820	126,370	38,140	19,930	8,380	459,150
LAMBTON	**0-14**	**15-44**	**45-64**	**65-74**	**75-84**	**85+**	**Total**
2001	24,180	49,710	32,990	11,165	6,975	1,945	126,975
2002	23,693	50,198	34,065	11,134	7,181	2,029	128,301
2003	23,119	50,111	35,028	11,198	7,324	2,141	128,924
2004	21,871	49,124	36,682	11,879	7,414	2,492	129,462
2005	22,230	51,660	37,290	11,040	7,800	2,280	132,280
2006	21,570	51,000	38,140	11,200	7,880	2,420	132,200
2009	20,040	49,330	39,950	12,150	7,910	2,870	132,240
2011	19,240	48,580	40,480	13,010	7,960	3,150	132,390
2016	18,490	46,840	39,610	16,350	8,330	3,490	133,100
ESC LHIN	**0-14**	**15-44**	**45-64**	**65-74**	**75-84**	**85+**	**Total**
2001	120,965	260,760	143,650	45,980	29,545	8,755	609,660
2002	120,266	264,273	148,970	45,953	30,361	9,014	618,835
2003	119,247	266,009	154,025	46,149	30,919	9,443	625,773
2004	116,752	266,641	165,426	48,666	31,128	10,710	639,321
2005	118,170	274,810	164,930	45,870	32,810	9,790	646,360
2006	116,830	274,770	169,720	46,290	33,110	10,390	651,060
2009	113,630	273,850	183,060	49,730	33,030	12,050	665,320
2011	111,720	274,420	190,110	52,840	33,030	12,990	675,070
2016	111,100	276,710	197,440	65,960	34,340	14,310	699,820
ONTARIO	**0-14**	**15-44**	**45-64**	**65-74**	**75-84**	**85+**	**Total**
2001	2,232,750	5,005,840	2,699,270	818,170	503,930	150,070	11,410,045
2002	2,216,840	5,478,348	2,263,875	880,771	553,541	155,999	12,109,369
2003	2,215,375	5,481,906	2,273,023	881,099	554,514	160,746	12,122,621
2004	2,286,780	5,465,790	3,059,670	849,170	564,070	167,240	12,392,720
2005	2,273,670	5,494,240	3,169,720	858,930	577,650	176,660	12,550,870
2006	2,261,940	5,520,310	3,281,650	871,530	589,800	187,720	12,712,950
2009	2,238,950	5,577,470	3,601,320	946,250	613,130	220,070	13,197,190
2011	2,229,010	5,635,590	3,775,200	1,012,510	626,680	240,070	13,519,060
2016	2,277,190	5,794,280	3,994,800	1,289,180	675,160	280,320	14,310,930

*Ministry of Finance Population Projections



Observations

- The population of ESC LHIN is projected to rise to 699,820 by 2016, up from the estimated 651,060 in 2006 – a 7% increase
- Chatham-Kent is the only community that is projected to have a population decline during the 2006 to 2016 period

4.3 Ethnic Origin

Definition

- Number of persons who report belonging to a specific ethnic, cultural, visible minority or aboriginal group
- Ethnic origin refers to the ethnic or cultural group/s to which a person's ancestors belong
- Visible minority refers to persons (other than aboriginal persons) who are non-Caucasian in race or non-white in colour

Significance/Uses

- Cultural values and beliefs influence health seeking, utilization and compliance behaviours
- Useful in planning culturally appropriate services

Limitations

- Self-reporting may not be accurate because ethnicity may be interpreted as citizenship, nationality, language or mother tongue
- A person's ethnicity may not directly reflect their home language or mother tongue
- Changes in composition over time may be due to changes in collection methods during different Census years. 1996 was the first year that "Canadian" appeared as an option for ethnic origin

Source

- 2001 Census, Statistics Canada.

Population by Ethnic Origin, 2001

Planning Area	Total Population	Multiple Origins*	Single Origin
Chatham-Kent	105,850	46%	54%
Essex	371,085	41%	59%
Lambton	125,560	46%	54%
ESC LHIN	602,495	43%	57%
Ontario	11,285,550	39%	61%

As ratio to Ontario percentages

Planning Area	Multiple Origins*	Single Origin
Chatham-Kent	1.18	0.89
Essex	1.05	0.97
Lambton	1.17	0.89
ESC LHIN	1.10	0.94
Ontario	1.00	1.00

*Multiple origins are individuals who indicate that they belong to more than one ethnic group. Rankings include individuals reporting multiple ethnic origins as a percentage of the total population.

Visible Minority and Aboriginal Identity, 2001

	Visible Minority		Aboriginal Identity	
Planning Area	**Persons**	**Percent**	**Persons**	**Percent**
Chatham-Kent	4,035	3.8%	2,085	2.0%
Essex	42,185	11.4%	4,435	1.2%
Lambton	2,825	2.3%	5,284	4.3%
ESC LHIN	49,045	8.1%	11,804	2.0%
Ontario	2,153,045	19.1%	188,315	1.7%

Source: 2001 Census Statistics Canada

As Ratio to Ontario Percentages

Planning Area	Visible Minority	Aboriginal Identity
Chatham-Kent	0.20	1.18
Essex	0.60	0.71
Lambton	0.12	2.53
ESC LHIN	0.42	1.18
Ontario	1.00	1.00

Source: 2001 Census Statistics Canada

Self-Perception of Aboriginal Identity, 2001

	Total Aboriginal identity population		N.A. Indian single response		Métis single response		Inuit single response		Multiple Aboriginal responses		Aboriginal responses not included elsewhere	
Planning Area	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Chatham-Kent	2,080	2.0%	1,465	1.4%	575	0.5%	-	0.0%	10	0.0%	40	0.0%
Essex	4,450	1.2%	2,790	0.8%	1,405	0.4%	25	0.0%	95	0.0%	135	0.0%
Lambton	5,370	4.3%	4,630	3.7%	635	0.5%	15	0.0%	25	0.0%	55	0.0%
ESC LHIN	11,900	2%	8,885	1.5%	2,615	0.4%	40	0.0%	130	0.0%	230	0.0%
Ontario	188,315	2%	131,560	1.2%	48,340	0.4%	1,375	0.0%	1,695	0.0%	5,345	0.0%

As Ratio to Ontario Percentages

Planning Area	Total Aboriginal identity population	N.A. Indian single response	Métis single response	Inuit single response	Multiple Aboriginal responses	Aboriginal responses not included elsewhere
Chatham-Kent	1.18	1.19	1.27	0.00	0.63	0.80
Essex	0.72	0.64	0.88	0.55	1.70	0.77
Lambton	2.56	3.16	1.18	0.98	1.33	0.92
ESC LHIN	1.18	1.27	1.01	0.54	1.44	0.81
Ontario	1.00	1.00	1.00	1.00	1.00	1.00

Observations

- The ESC LHIN population was primarily of European descent
- Canadian was the most commonly reported ethnic origin
- French ranked second in Essex, while English ranked second for Chatham-Kent, Lambton and Ontario
- Approximately 11% of Essex residents, 4% of Chatham-Kent and 2% of Lambton residents belong to a visible minority group compared with 19% for Ontario
- The minority groups most commonly reported by Essex residents were Black, Arab and South Asian
- In Chatham-Kent, the most commonly reported minority groups were Black, Southeast Asian and Chinese
- In Lambton County, the most commonly reported groups were South Asian, Chinese and Black
- Erie St. Clair LHIN has a 1.18 times higher aboriginal population than the province (2% vs. 1.7%), predominantly due to Lambton's aboriginal population of 4% (2.56 times the Ontario percentage) and Chatham-Kent with 2%
- It should be noted that although the Lambton aboriginal population includes the residents of Walpole Island, these residents typically seek their health services in Chatham-Kent

4.4 Period of Immigration

Definition

- Number of people by the year they obtained landed immigrant status
- "Immigrant" refers to individuals who have been granted the right to live in Canada permanently by immigration authorities. Many become Canadian citizens eventually. The category excludes non-permanent residents (refugee claimants, holders of employment authorizations, student visas, or Minister's permits and their families)

Significance/Uses

- Period of immigration may be an indication of acculturation into mainstream culture
- New migrants may have different health care needs and levels of utilization of services from those who lived in Canada longer
- New migrants may have difficulty accessing health care services
- Useful in planning culturally sensitive services for communities with diverse ethnic groups

Limitations

- Period of immigration may vary between different Census years, thus affecting comparability

Source

- 2001 Census, Statistics Canada

Immigrants by Period of Immigration, 2001

	Immigrants		Before 1961		1961-1970		1971-1980		1981-1990		1991-1995		1996-2001	
Planning Area	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Chatham-Kent	10,085	10%	3,800	3.6%	1,540	1.5%	1,650	1.6%	1,535	1.5%	800	0.8%	760	0.7%
Essex	79,775	21%	15,930	4.3%	12,615	3.4%	11,490	3.1%	12,860	3.5%	10,915	2.9%	15,965	4.3%
Lambton	14,515	12%	6,015	4.8%	2,860	2.3%	2,490	2.0%	1,665	1.3%	710	0.6%	775	0.6%
ESC LHIN	104,375	17%	25,745	4.3%	17,015	2.8%	15,630	2.6%	16,060	2.7%	12,425	2.1%	17,500	2.9%
Ontario	3,030,080	27%	502,735	4.5%	427,795	3.8%	496,680	4.4%	580,495	5.1%	483,635	4.3%	538,735	4.8%

As ratio to Ontario Percentages

Planning Area	Immigrants	Before 1961	1961-1970	1971-1980	1981-1990	1991-1995	1996-2001
Chatham-Kent	0.35	0.81	0.38	0.35	0.28	0.18	0.15
Essex	0.80	0.96	0.90	0.70	0.67	0.69	0.90
Lambton	0.43	1.08	0.60	0.45	0.26	0.13	0.13
ESC LHIN	0.65	0.96	0.75	0.59	0.52	0.48	0.61
Ontario	1.00	1.00	1.00	1.00	1.00	1.00	1.00

Resident Generation, 2001

Planning Area	1st generation		2nd generation		3rd generation and over	
Chatham-Kent	9,935	12%	14,495	17%	60,160	71%
Essex	77,360	26%	61,260	21%	156,790	53%
Lambton	14,485	14%	18,680	18%	68,020	67%
ESC LHIN	101,780	21%	94,435	20%	284,970	59%
Ontario	2,951,230	33%	1,808,580	20%	4,288,230	47%

As ratio to Ontario Percentages

Planning Area	1st generation	2nd generation	3rd generation and over
Chatham-Kent	0.36	0.86	1.50
Essex	0.80	1.04	1.12
Lambton	0.44	0.92	1.42
ESC LHIN	0.65	0.98	1.25
Ontario	1.00	1.00	1.00

2001 Census, Data Warehouse

Observations

- Chatham-Kent and Lambton have a low proportion of immigrants (10 and 12% respectively) compared to the province (27%), while Essex has a much higher proportion at 22%
- The percentage of recent immigrants (1996 – 2001) is very low for Chatham-Kent and Lambton, while Essex has a very similar rate to the province
- It is noted that recent immigrants may have different health care needs and may face challenges in accessing health care services due to cultural or language barriers. Access to primary care will also present a challenge for this population which numbers almost 16,000 in Essex County
- Essex County immigration rates were similar to those for Ontario, but much higher than Chatham-Kent and Lambton. The high rate of immigration in Essex County has implications for the planning and delivery of local health care services. The two, most notable being the provision of services in a culturally appropriate fashion and identifying unique medical conditions more prevalent in certain ethnic groups
- 1.4 to 1.5 times more Chatham-Kent and Lambton residents are third generation residents compared to Ontario. Essex is higher than Ontario as well, but only 1.12 times higher
- Chatham-Kent and Lambton have only 0.36 to 0.44 times as many first generation residents as Ontario overall. Essex is also less at 0.80

4.5 Knowledge of Official Languages and Mother Tongue

Definition

- "Knowledge" is defined as the ability to conduct a conversation in the relevant language
- "Mother Tongue" is defined by the first language learned in childhood and still understood

Significance/Uses

- People who cannot converse in either official language will have reduced access to health information and services
- Useful for identifying the people most in need of translation or cultural interpretation services
- Provides information on the cultural makeup of the community
- Useful for development of culturally and linguistically specific programs
- Useful in planning for population-based services
- Useful in developing community engagement processes

Limitations

- Knowledge of official languages is based on the respondent's assessment of his or her ability to converse in an official language
- Mother tongue reflects the first language learned but does not necessarily reflect the usual language habits of the respondent

Source

- 2001 Census, Statistics Canada

Knowledge of an Official Language, 2001

	English only		French only		English and French		Neither English nor French	
Planning Area	Number	%	Number	%	Number	%	Number	%
Chatham-Kent	97,775	92%	85	0.1%	7,505	7%	490	0.5%
Essex	326,445	88%	610	0.2%	37,640	10%	6,395	1.7%
Lambton	116,635	93%	115	0.1%	8,445	7%	370	0.3%
ESC LHIN	540,855	90%	810	0.1%	53,590	9%	7,255	1.2%
Ontario	9,690,745	86%	42,305	0.4%	1,319,715	12%	232,780	2.1%

As ratio to Ontario percentages

Planning Area	English only	French only	English and French	Neither English nor French
Chatham-Kent	1.08	0.21	0.61	0.22
Essex	1.02	0.44	0.87	0.84
Lambton	1.08	0.24	0.58	0.14
ESC LHIN	1.05	0.36	0.76	0.58
Ontario	1.00	1.00	1.00	1.00

Mother Tongue, 2001

	Single responses		English		French		Non-official languages	
Planning Area	Number	%	Number	%	Number	%	Number	%
Chatham-Kent	105,110	99%	92,555	87%	3,565	3%	8,985	8%
Essex	365,910	99%	269,985	73%	14,300	4%	81,625	22%
Lambton	124,620	99%	112,965	90%	2,570	2%	9,085	7%
ESC LHIN	595,640	99%	475,505	79%	20,435	3%	99,695	17%
Ontario	11,122,940	99%	7,965,225	71%	485,630	4%	2,672,085	24%

As ratio to Ontario percentages

Planning Area	Single responses	English	French	Non-official languages
Chatham-Kent	1.01	1.24	0.78	0.36
Essex	1.00	1.03	0.90	0.93
Lambton	1.01	1.27	0.48	0.31
ESC LHIN	1.00	1.12	0.79	0.70
Ontario	1.00	1.00	1.00	1.00

Language Spoken at Home, 2001

	Single Language						Multiple Language	
	English		French		Non-official languages		Non-Official languages	
Planning Area	Number	%	Number	%	Number	%	Number	%
Chatham-Kent	97,495	92%	350	0.3%	1,930	1.8%	735	0.7%
Essex	291,570	79%	1,840	0.5%	25,145	6.8%	17,575	4.7%
Lambton	117,745	94%	440	0.4%	1,180	0.9%	1,640	1.3%
ESC LHIN	506,810	84%	2,630	0.4%	28,255	4.7%	19,950	3.3%
Ontario	8,456,585	75%	164,550	1.5%	905,770	8.0%	416,210	3.7%

as ratio to Ontario percentages

	Single Language			Multiple Language
Planning Area	English	French	Non-official languages	Non-Official languages
Chatham-Kent	1.23	0.23	0.23	0.19
Essex	1.05	0.34	0.84	1.28
Lambton	1.25	0.24	0.12	0.35
ESC LHIN	1.12	0.30	0.58	0.90
Ontario	1.00	1.00	1.00	1.00

Languages Spoken at Work, 2001

	English		French		Non-official languages		French and non-official language	
Planning Area	Number	%	Number	%	Number	%	Number	%
Chatham-Kent	58,395	97%	70	0.1%	50	0.1%	-	0.0%
Essex	193,825	93%	580	0.3%	1,900	0.9%	20	0.0%
Lambton	67,825	98%	130	0.2%	25	0.0%	-	0.0%
ESC LHIN	320,045	95%	780	0.2%	1,975	0.6%	20	0.0%
Ontario	5,787,225	89%	31,935	0.5%	59,010	0.9%	710	0.0%

As ratio to Ontario percentages

Planning Area	English	French	Non-official languages	French and non-official language
Chatham-Kent	1.09	0.24	0.09	-
Essex	1.05	0.57	1.01	0.88
Lambton	1.10	0.38	0.04	-
ESC LHIN	1.07	0.47	0.65	0.54
Ontario	1.00	1.00	1.00	1.00

Observations

- A very low percentage of the population across the ESC LHIN has no knowledge of either English or French compared with the province
- This small population, which represents approximately 6,400 people in Essex County, could experience more social isolation and encounter significant barriers to access to health care
- A higher percentage of the population identified French as their mother tongue in Essex and Chatham-Kent, with Essex being very similar to the province
- Very low percentages of Chatham-Kent and Lambton residents do not speak an official language at home (0.23 and 0.12 times the Ontario percentages respectively)
- Virtually all Chatham-Kent and Lambton residents speak an official language at work. The Essex rate, however, is the same as Ontario's at less than 1%

4.6 Low Income Incidence

Definition

- Persons living below Statistics Canada's Low Income Cut-Off (LICO). LICO is defined based on the percentage of income spent on basic necessities (food, clothing, shelter). The rate varies for type of family unit and by urban/non-urban setting. It is adjusted annually

Significance/Uses

- People with low income have increased risk of illness and mortality, as well as greater utilization of health services. Low income may also be used to identify groups at risk for marginalization, malnutrition, poor housing conditions, learning problems in children, etc.
- Low income incidence is used to measure the proportion of population/families considered to be poor. Education and income are considered the two main indicators of socio-economic status. Low SES is associated with low-skilled jobs, higher unemployment rates, unfavourable lifestyle and living conditions and a greater prevalence of health problems and disability
- Because many aspects of health care are paid directly by the patient/family, high levels of low income indicate less ability to pay for prescribed services
- Useful for planning population-based services

Limitations

- There is an arbitrary element in the criteria used to define LICO based on amount spent on food, clothing and shelter. This may vary from one region to another
- LICOs are income levels necessary for material survival, not indicators of general welfare and provide no

information on the intensity or duration of poverty

- LICOs do not consider the near poor or low wage earners with incomes barely above the poverty line
- Because certain sub groups (young adults, aboriginal groups and the homeless) are not as well counted, actual LICO incidence may be underreported

Source

- 2001 Census, Statistics Canada.

Percentage of Low Income by Living Arrangement, 2000

	All Private Households		Economic Families		Unattached Individuals	
Planning Area	**Number****	**%**	**Number****	**%**	**Number****	**%**
Chatham-Kent	13,300	13	3,030	10	4,200	33
Essex	45,485	12	10,105	10	13,825	32
Lambton	14,165	12	3,165	9	4,580	31
ESC LHIN	72,950	12	16,300	10	22,605	32
Ontario	1,611,505	14	364,320	12	445,705	34

**based on percent and number of households by type

As ratio to Ontario percentages

Planning Area	All Private Households	Economic Families	Unattached Individuals
Chatham-Kent	0.88	0.85	0.97
Essex	0.86	0.84	0.94
Lambton	0.81	0.76	0.92
ESC LHIN	0.85	0.82	0.94
Ontario	1.00	1.00	1.00

Average Family Incomes by Family Type, 2000

	Census Families		Married Couples		Common-Law Couples		Male Lone Parent		Female Lone Parent	
Planning Area	Income	Sign. Diff.	Income	Sign. Diff.	Income	Sign. Diff.	Income	Sign. Diff.	Income	Sign. Diff.
Chatham-Kent	$ 64,754	↓	$ 71,461	↓	$ 56,738	↓	$ 46,141	↓	$ 32,354	↓
Essex	$ 74,191		$ 81,555		$ 70,084		$ 57,404		$ 37,733	
Lambton	$ 67,245	↓	$ 73,881	↓	$ 57,283	↓	$ 51,103		$ 31,577	↓
ESC LHIN	71,032		78,107		64,516		54,139		35,694	
Ontario	73,849	n.a.	81,221	n.a.	68,295	n.a.	53,326	n.a.	38,110	n.a.

Median Family Incomes by Family Type, 2000

Planning Area	Census Families Income	Married Couples Income	Common-Law Couples Income	Male Lone Parent Income	Female Lone Parent Income
Chatham-Kent	$ 56,612	$ 63,224	$ 51,618	$ 44,473	$ 26,445
Essex	$ 64,952	$ 72,279	$ 65,383	$ 51,588	$ 31,248
Lambton	$ 58,582	$ 65,239	$ 49,344	$ 40,593	$ 27,065
ESC LHIN	$ -	$ -	$ 145,995	$ 76,704	$ -
Ontario	$ 61,024	$ 67,549	$ 59,505	$ 44,566	$ 31,776

As ratio to Ontario percentages

Planning Area	Census Families	Married Couples	Common-Law Couples	Male Lone Parent	Female Lone Parent
Chatham-Kent	0.93	0.94	0.87	1.00	0.83
Essex	1.06	1.07	1.10	1.16	0.98
Lambton	0.96	0.97	0.83	0.91	0.85
ESC LHIN	-	-	-	-	-
Ontario	1.00	1.00	1.00	1.00	1.00

Composition of Income, 15 years and older, 2000

(Number and percentages)

	Employment Income		Government Transfer		Other	
Planning Area	Number	%	Number	%	Number	%
Chatham-Kent	60,587	74.5	10,654	13.1	10,084	12.4
Essex	223,237	79.9	27,381	9.8	28,498	10.2
Lambton	69,968	72.6	12,047	12.5	14,360	14.9
ESC LHIN	353,863	77.4	50,042	10.9	52,909	11.6
Ontario	6,767,067	78.7	842,659	9.8	988,834	11.5

As ratio to Ontario percentages

Planning Area	Employment Income	Government Transfer	Other
Chatham-Kent	0.95	1.34	1.08
Essex	1.02	1.00	0.89
Lambton	0.92	1.28	1.30
ESC LHIN	0.98	1.12	1.01
Ontario	1.00	1.00	1.00

Observations

- Families and individuals in all Planning Areas have between 0.82 and 0.92 lower rates of low income than Ontario overall
- Average incomes for all family types are significantly lower in Chatham Kent and Lambton compared to Ontario. Essex is not significantly different from Ontario, although it is numerically higher for all family types expect female lone parent led families
- Median family incomes are lower in Chatham Kent and Lambton and are especially low for female lone parent led families. Male lone parent led are closest to the Ontario median, but still generally low
- Chatham Kent and Lambton residents are 1.34 and 1.28 times more likely to receive their income from government transfers compared to Ontario residents

4.7 Education

Definition

- Persons aged 20 years and over by level of schooling achieved
- School attendance for persons 15 to 24 years old

Significance/Uses

- Education is an indicator of socio demographic status (SES)
- Research has demonstrated a direct relationship between education and health status
- People with lower education will require different communication on health information
- School attendance provides a possible site for community engagement and for health information programming
- Useful in planning for population based planning

Limitations

- Education levels by age group. An older age community may show a higher percentage of lower education than a younger age community due to improved access to education over time
- Higher education does not ensure a good job or higher income

Source

- 2001 Census, Statistics Canada

Schooling Level, Persons 20 Years and Older, 2001

Population 20 years and older

	Less than Grade 9		Partial High School		High School Graduation		Trades, College, University	
Planning Area	Number	%	Number	%	Number	%	Number	%
Chatham-Kent	8,530	11%	30,155	40%	17,170	22%	37,655	49%
Essex	26,530	10%	92,980	34%	47,250	17%	150,590	56%
Lambton	6,650	7%	33,225	36%	17,585	19%	51,875	57%
ESC LHIN	41,710	10%	156,360	36%	82,005	19%	240,120	55%
Ontario	723,360	9%	2,577,275	31%	1,402,505	17%	4,981,525	60%

As ratio to Ontario percnetages

Planning Area	Less than Grade 9	Partial High School	High School Graduation	Trades, College, University
Chatham-Kent	1.28	1.27	1.33	0.82
Essex	1.12	1.11	1.03	0.93
Lambton	0.83	1.16	1.13	0.94
ESC LHIN	1.09	1.15	1.11	0.91
Ontario	1.00	1.00	1.00	1.00

School Attendance, 15 to 24 year olds, 2001

(Numbers and percentages)

	Not attending school		Attending school full time		Attending school part time	
Planning Area	**Number**	**%**	**Number**	**%**	**Number**	**%**
Chatham-Kent	6,120	42%	7,780	54%	635	4%
Essex	19,465	38%	28,280	56%	2,880	6%
Lambton	6,275	37%	9,985	59%	640	4%
ESC LHIN	31,860	39%	46,045	56%	4,155	5%
Ontario	520,035	35%	883,020	60%	76,625	5%

As ratio to Ontario percentages

Planning Area	**Not attending school**	**Attending school full time**	**Attending school part time**
Chatham-Kent	1.20	0.90	0.84
Essex	1.09	0.94	1.10
Lambton	1.06	0.99	0.73
ESC LHIN	1.10	0.94	0.98
Ontario	1.00	1.00	1.00

Observations

- Chatham-Kent residents are 1.28 times more likely to have less than Grade 9 education compared to Ontario overall
- Lambton residents are only 0.83 times as likely to have less than Grade 9 education compared to Ontario overall
- All Planning Areas are less likely to not have a trade certificate, college or university experience compared to Ontario
- Chatham-Kent residents 15 to 24 year olds are 1.2 times more likely to be out of school compared to Ontario residents
- Essex residents 15 to 24 years-old are 1.1 times more likely to be in part-time school than Ontario residents

4.8 Seniors

Definition

- Seniors are persons aged 65 years and older

Significance/Uses

- Seniors are high per capita users of health care services
- The number of seniors is increasing rapidly in most communities across Ontario
- In-home assistance for persons receiving CCAC services. Those living alone are at a severe disadvantage

Limitations

- Hours of care provided to seniors are based on recall only. They may not be accurate

Source

- 2001 Census, Statistics Canada

Living Arrangements of Seniors, 2001

	Persons 65 yrs and over		Living in a Family		Living with relatives		Living with non-relatives only		Living alone	
Planning Area	Number	%**	Number	%	Number	%	Number	%	Number	%
Chatham-Kent	14,810	14%	9,295	63%	390	3%	125	1%	5,000	34%
Essex	44,940	12%	29,260	65%	1890	4%	500	1%	13,285	30%
Lambton	18,955	15%	12,670	67%	420	2%	165	1%	5,700	30%
ESC LHIN	78,705	13%	51,225	65%	2,700	3%	790	1%	23,985	30%
Ontario	1,379,970	12%	905,390	66%	84,505	6%	20,525	1%	369,550	27%

**percent of total population

As ratio to Ontario percentages

Planning Area	Persons 65 yrs and over	Living in a Family	Living with relatives	Living with non-relatives only	Living alone
Chatham-Kent	1.14	0.96	0.43	0.57	1.26
Essex	0.99	0.99	0.69	0.75	1.10
Lambton	1.23	1.02	0.36	0.59	1.12
ESC LHIN	1.00	1.00	1.00	1.00	1.00
Ontario	1.07	0.99	0.56	0.67	1.14

Unpaid Care or Assistance to Seniors, 2001

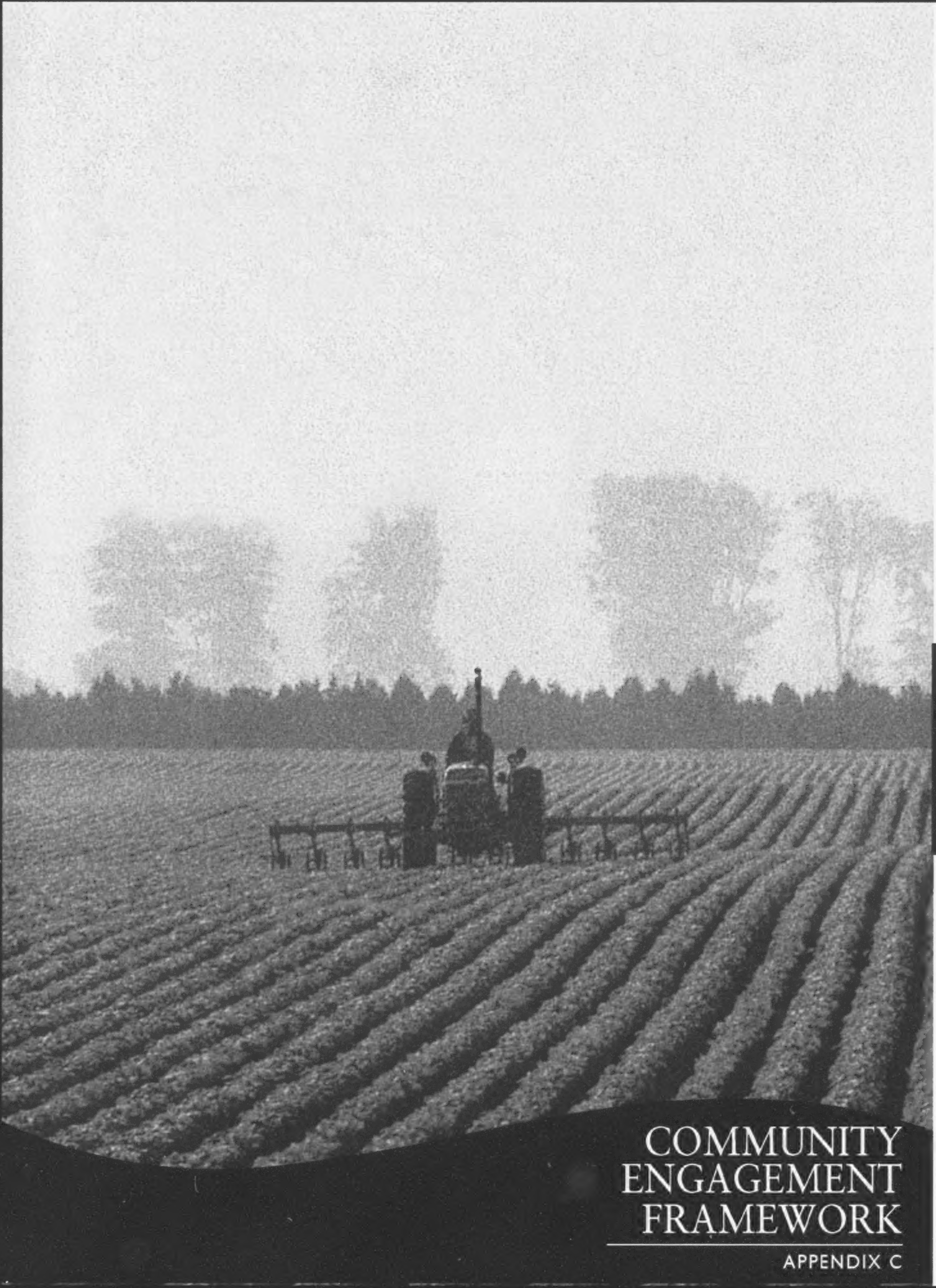
	No hours		Less than 5 hours		5 to 9 hours		10 to 19 hours		20 hours or more	
Planning Area	Number	%	Number	%	Number	%	Number	%	Number	%
Chatham-Kent	66,880	79%	11,280	13%	3,935	5%	1,195	1%	1,295	2%
Essex	243,465	82%	31,560	11%	11,660	4%	4,300	1%	4,435	2%
Lambton	80,200	79%	13,425	13%	4,675	5%	1,760	2%	1,125	1%
ESC LHIN	390,545	81%	56,265	12%	20,270	4%	7,255	2%	6,855	1%
Ontario	7,406,730	82%	1,029,485	11%	363,210	4%	126,385	1%	122,225	1%

As ratio to Ontario percentages

Planning Area	No hours	Less than 5 hours	5 to 9 hours	10 to 19 hours	20 hours or more
Chatham-Kent	0.97	0.01	0.01	1.01	1.13
Essex	1.01	0.03	0.03	1.04	1.11
Lambton	0.97	0.01	0.01	1.25	0.82
ESC LHIN	0.99	0.06	0.06	1.08	1.05
Ontario	1.00	1.00	1.00	1.00	1.00

Observations

- The percentage of seniors in local population is 1.23 times higher in Lambton and 1.14 times higher in Chatham-Kent than in Ontario overall
- 1.26 times as many Chatham-Kent seniors and 1.12 times as many Lambton seniors live alone compared to Ontarians overall
- Chatham-Kent and Lambton residents report providing much more unpaid care to seniors than Ontarians overall



COMMUNITY ENGAGEMENT FRAMEWORK

APPENDIX C

ERIE ST. CLAIR LOCAL HEALTH INTEGRATION NETWORK

COMMUNITY ENGAGEMENT FRAMEWORK

APPENDIX C

Erie St. Clair
LOCAL HEALTH INTEGRATION NETWORK
RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
d'Érie St. Clair

Health*Care* Matters

A PROPOSED STRATEGY TO ENGAGE OUR COMMUNITY

April 2006

Ontario

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Letter from the Chair and Chief Executive Officer

Health Care Matters to Ontarians. More than that, receiving quality health care *close to home* matters to Ontarians. That is the cornerstone of a great heath care system…of our system.

Health Care Matters is inspirational for us at the Erie St. Clair Local Health Integration Network (LHIN). It serves to remind us, and all who we encounter, that **health care** matters to our residents, to our health care providers, to our economy and it matters to the overall health of our community. We also have several **health care matters** that need our attention. We need to ensure continuity of care for patients in our LHIN. We need to replicate the extraordinary integration successes we have already seen in some sectors. We must tailor the services provided in our LHIN to really meet the needs of our patients and their families.

No matter how you look at it, ***Health Care Matters***.

You will see this phrase, our inspiration, throughout this document and in communications yet to come. In fact, the community engagement framework outlined in these pages is entitled ***Health Care Matters***. It provides the framework for how we intend to work with health care providers and members of the community, to gather and prioritize the health care needs for our region.

It's particularly important that we focus on what matters in our LHIN as we enter the new health care era created by the passage of Bill 36, the *Local Health Systems Integration Act*. The Act mandates that we engage members of the community to establish relationships and identify opportunities to build on existing positive integration initiatives. Beyond it being a mandate for us, we *want* to engage the community. We believe that talking with the people who know our system best, those who use it and those who deliver services within it, is the best way to develop an Integrated Health Services Plan for our community. Our goal is to work with providers and members of the public to ensure positive patient outcomes.

Our continuing objective as we engage members of the community will be to ensure they continue to receive quality care close to home when they need it.

As you'll see in the pages that follow, our intention is not to use a "one size fits all" approach to community engagement. We intend to talk with health care stakeholders in ways that make the most sense to them, for this region. We believe having a tailored plan to reach out to our varied constituents is an important step toward achieving a truly Integrated Health Services Plan, tailored to our community needs.

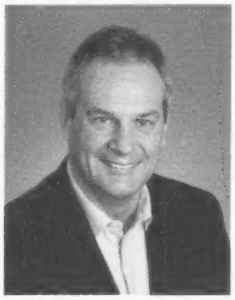
We are encouraged by the positive response and input we have received from members of our community and we look forward to working with local health care providers and the public in the months to come.

So, as the first step in encouraging a dialogue about health care in the Erie St. Clair LHIN, we welcome your feedback on this framework, ***Health Care Matters – A Proposed Strategy to Engage our Community***. Most importantly, we invite you to participate in this engagement process because together we can make our health system even better.

Sincerely on behalf of the Board,

Mina Grossman Ianni

Mina Grossman-Ianni
Chair – Board of Directors
Erie St. Clair
Local Health Integration Network

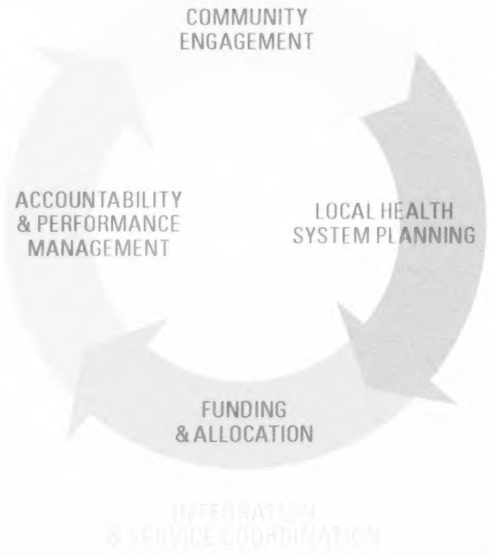


Gary Switzer
Chief Executive Officer
Erie St. Clair
Local Health Integration Network

Introduction

In keeping with the LHIN mandate to improve access to coordinated, quality health care for the people of Ontario, we will work closely with local health care providers and the public, to develop and implement local plans and priorities for improved health care in our region.

This process must be open and transparent and must build upon the integration successes that already exist within our LHIN. For example, the Ontario Stroke Strategy is one integration success with benefits for Erie St. Clair. Coordinated stroke care is offered through District Stroke Centres and Secondary Prevention clinics in Windsor and Chatham. A District Stroke Centre offers stroke care in Sarnia and a Secondary Prevention clinic is also planned for the community. These sites share knowledge and expertise and are linked to academic expertise at London Health Sciences Centre. The Ontario Stroke Strategy is an integration example that should act as a model of success as we work with providers to build our Integrated Health Services Plan (IHSP), which will become the planning road map for our LHIN. This is the kind of success we're looking for in all segments of our health care system.


COMMUNITY ENGAGEMENT
LOCAL HEALTH SYSTEM PLANNING
FUNDING & ALLOCATION
INTEGRATION & SERVICE COORDINATION
ACCOUNTABILITY & PERFORMANCE MANAGEMENT

LHINs are a "made-in-Ontario" solution and will work to improve planning, management and coordination of services. LHINs will also streamline and improve decision-making, and will help realize the government's health care goals of reducing wait times, improving access to doctors and nurses, and keeping Ontarians healthy.

Local Health Integration Networks are focused on achieving an integrated system that:

- provides a seamless experience for the patient,
- leads to better matches between the services provided and the multiple needs of patients and families, and
- makes effective and efficient use of the resources and capacity within the system.

To develop a health care system that truly meets the needs of patients and residents, all partners in the system need to work together. Through the community engagement process, we will meet with our stakeholders and the public to build strong and enduring relationships, bridge gaps and identify integration opportunities. We will also engage with stakeholders across LHIN boundaries to ensure continuous care for our residents who receive care in other geographic areas.

Health Care Matters is an introduction to the objectives, guiding principles and general methods that will be employed, tested and evaluated as we seek to involve citizens, consumers, providers, and other stakeholders in our key functions. We will incorporate community feedback into the planning and decision-making process, and we are accountable to the Ministry of Health and Long-Term Care for our performance. This framework is a commitment from the Erie St. Clair LHIN to place collaborative engagement at the centre of our activities. As a core function, community engagement will help to shape the look and feel of our organization and culture.

Community Engagement

We are working with the entire community, including health care providers, patients and caregivers. Meeting with our health care providers and learning about their organizations will be the cornerstone of what ***Health Care Matters*** is all about. We believe that health care providers are truly experts in their respective fields. We also believe that patients and their families are experts in how the system works for them.

Increasing community control over decisions affecting communities is one of the major contributors to a healthier population. We will work closely with providers and members of the public to identify local health care priorities and develop solutions to make a more patient-centred health care system in our region.

We understand that engaging with all members of the community is an ongoing process and we encourage our health care providers and members of the public to take an active role in all aspects of our engagement activities.

> *Research indicates that close to 80 per cent of Canadians believe that it is very important for citizens to be involved in major decisions affecting the health care system (EKOS, 2002).*

In keeping with the government's broader commitment to be responsive to health needs at the local level, we will aim to keep community groups informed, engaged and working together to strengthen local health care services in our region.

Defining Community

We are defining community in a broad sense to incorporate patients and their families, residents of the Erie St. Clair geographic area, all health care providers, and all organizations that are involved with or concerned about health care in our area, and in the neighbouring LHINs. The following chart provides a detailed list of the various communities and partners we will engage to develop a patient-centred health care system.

Community Group	Description
Residents/public	Individuals who reside within the LHIN boundaries. The general public is the largest community group and must be involved in the community engagement process. Members of the public have a strong desire to be involved in the health care system and take responsibility for their own health and decisions.
Clients/patients/consumers/advocacy groups	Individuals who receive programs or services from health service providers have a keen interest in changes to the health system. This should also take into consideration the cultural diversity of the LHIN, such as our Aboriginal and Francophone populations.
Transfer payment providers (agencies that will be funded directly by the LHIN)	• Community Care Access Centres • Community Health Centres • Community Support Services • Hospitals • Long-Term Care Homes • Mental Health and Addictions Services
Other service providers	• Ambulance Services • Human Services Providers (e.g., children's mental health, police, education) • Nurses/Nurse Practitioners • Physicians (family physicians and specialists) • Public Health • Other (e.g., private retirement homes)
Local networks	• Cancer Services Networks • Dementia Networks • Long-Term Care Provider Networks • Mental Health Coordination Networks • Palliative Care Networks • Rehabilitation Networks • Social Planning Councils
Provincial networks	• Cancer Care Ontario • Cardiac Care Network • Stroke Strategy

Community Group	Description
Cross-LHIN initiatives	• Cancer Services • Cardiac Care • Stroke Strategy
Stakeholders outside the LHIN geographic boundaries	• Academic Health Science Centres in surrounding LHINs • Regional Geriatric Programs in surrounding LHINs • Tertiary-Level Services in surrounding LHINs • Tertiary Psychiatric Services in surrounding LHINs • Universities and Community Colleges • Other LHINs
Ministry of Health and Long-Term Care	• Minister of Health and Long-Term Care • Ministry of Health and Long-Term Care Health System Investment & Funding Public Health & the Chief Medical Officer of Health Health System Strategy Health System Accountability & Performance Health System Information Management
Other government	• Municipality of Chatham-Kent • City of Sarnia • City of Windsor • County of Essex • County of Lambton • Ministry of Children and Youth Services • Ministry of Community and Social Services • Ministry of Health Promotion • MPPs • Municipalities and Mayors
Other	• Funders United Way • Associations Provincial Associations Professional Associations Regulatory Colleges Health Care Industry Associations • Business Community Chambers of Commerce Large employer groups • Organized Labour

Proposed Community Engagement Framework

Our job is to develop and maintain positive relationships with you, the groups and individuals involved in health care. We encourage community involvement in all activities, so that we can develop a health care system that truly meets the needs of our citizens.

Planning Assumptions

In developing this strategy, we have assumed that:

Planning Assumption	Description
The Community Engagement Framework is a living document.	The document will change based on the feedback received throughout the community engagement process.
Community engagement and planning will occur in the community.	This means at the community level, at Erie St. Clair LHIN level, across other LHINs and at the provincial level.
The levels and approaches of community engagement will vary.	A variety of engagement tools will be used depending on the issue to be addressed and the most appropriate means to engage the community.
All health care providers will be actively engaged.	Providers' input is critical to help develop an understanding of the system and any emerging issues that will impact health or health care delivery.
Partners will be committed to the community engagement process.	Partners will participate actively in engagement activities.
The Community Engagement Framework will reflect the cultural and linguistic diversity of the community.	Erie St. Clair is home to 645,200 people, or 5.2 per cent of the population of Ontario. Two per cent of Erie St. Clair's population is Aboriginal and almost four per cent of the population is Francophone.

Goals and Objectives

The goals of ***Health Care Matters*** are to:

> **Focus on patients and their families** – We will place patients and their families at the centre of care and engage directly with those who are most knowledgeable

about their experience and degree of satisfaction with health care services – the citizens themselves.

Enhance local accountability – We will enhance accountability at the local level by providing opportunities for direct input into decision-making.

Balance priorities – Informing and engaging the public is the best approach to address community needs and community responsibilities. We will also foster a shared sense of responsibility for achieving balance among competing priorities.

Develop system capacity and sustainability – Communities are the best source of knowledge about their own needs and their own solutions. We will draw on this knowledge and capacity, to identify needs and gaps, and build sustainable, long-term solutions.

Our objectives are to:

Provide the community with balanced and objective information to assist in understanding the role and mandate of Local Health Integration Networks and the responsibilities and expectations of all involved.

Obtain feedback and make recommendations on service gaps and opportunities for service coordination and integration in the Erie St. Clair LHIN.

Work directly with the community throughout the process to **ensure that all concerns are consistently understood and considered**.

Partner and build relationships at each level in the LHIN community engagement process, including the identification and development of preferred integrated service delivery solutions.

Principles of ***Health Care Matters***

We are committed to ongoing dialogue with all partners affected by or involved in the health care system. To build productive, long-term relationships in the community, the Erie St. Clair LHIN commits to the following five basic principles:

Principles of Community Engagement	Description
Shared Vision	Working with the community to develop and implement plans that are consumer-centred, focused on population health, and consistent with legislative and regulatory requirements.
Mutual Respect	Respecting and including all of our partners. We will build relationships and engage communities using methods and levels of engagement that are appropriate to the groups and to the objectives that the LHIN is trying to achieve.
Accountability	Establishing a community engagement approach that enables timely and meaningful discussions based on relevant, accurate information and support for a mutual learning environment. Through ongoing evaluation, we will ensure that community engagement efforts are meeting established objectives.
Transparency	Using an open process and clearly stating our purpose, goals, objectives, and expectations. We will be transparent about how engagement activities will influence our decision-making.
Commitment	We are dedicated to working with community partners to achieve a patient-centred, sustainable health care system.

Techniques for Community Engagement

We propose to use the following continuum of engagement techniques, depending on the complexity of the issue at hand. As illustrated, the more complex the issue, and the greater the need for community involvement in decision-making, the more multi-faceted the engagement activities become.

The Community Engagement Continuum

LESS **COMPLEXITY OF ISSUE** **GREATER** →

INFORM AND EDUCATE	**CONSULT**	**INVOLVE**	**COLLABORATE**	**EMPOWER**

→ **LESS** **DEGREE OF PARTICIPATION IN DECISIONS** **GREATER**

INFORM AND EDUCATE	CONSULT	INVOLVE	COLLABORATE	EMPOWER
To provide accurate, timely, relevant and easy-to-understand information. This level of engagement provides opportunities for community members to understand the problems, alternatives and/or solutions. There is no potential to influence outcomes as this is one-way communication.	*To seek out and receive input on analyses, alternatives and/or solutions.* This level of engagement provides opportunities for dialogue with stakeholders. Consultation *may* result in changes to the final outcome.	*To work with stakeholders ensuring that concerns and aspirations are consistently understood and considered.* This level of engagement ensures that stakeholder concerns and aspirations are incorporated into outcomes of the process. Stakeholder involvement will influence the final outcome.	*To partner with stakeholders in all aspects of the issue including issue analysis, and development of alternatives and/or solutions.* This level of engagement ensures that there is direct involvement of stakeholders in all aspects of the process. Stakeholder involvement will significantly impact the final outcome.	*To ensure that decisions are made by stakeholders.* This is the most significant level of engagement whereby the accountability for decision-making resides with stakeholders. Stakeholder involvement will direct the final outcome.

Adapted from the IAP2 2000 Public Participation Spectrum & Arnstein, S. (1969) A ladder of citizen participation. Journal of the American Institute of Planners, 35: 216-224.

Approaches to Community Engagement

Effective community engagement involves a wide range of approaches. We believe that choosing the appropriate approach depends on the context of the situation, and the best ways to accommodate the range of interests in a community and to enhance community expression. The following chart illustrates some potential methods for engaging the community.

Engagement Level	Community Groups	Engagement Approaches
INFORM AND EDUCATE	• All stakeholders	• Fact/information sheets • Newsletters/brochures • Open houses • Web sites • Open forums or town hall meetings • Public service announcements • Paid advertisements • Media coverage
CONSULT	• Residents/Public • Clients/Patients/Consumers/ Advocacy groups • Providers • Other selected stakeholders as required	• Surveys or questionnaires (print, phone, or web-based) • Focus groups • Written submissions • Community or stakeholder research
INVOLVE	• Clients/Patients/Consumers/ Advocacy groups • Providers • Other selected stakeholders as required	• Small group workshops • Focus groups • Surveys • Online consultations • Public meetings • Deliberative polling • Stakeholder/public roundtables
COLLABORATE	• Clients/Patients/Consumers/ Advocacy groups • Providers • Other selected stakeholders as required	• Action planning events • Negotiation tables • Collaborations • Panels • Community advisory committees
EMPOWER	• Clients/Patients/Consumers/ Advocacy groups • Providers • Other selected stakeholders as required	• Citizen panels • Search conferences

A Proposed Approach to Community Engagement in Erie St. Clair LHIN

This engagement strategy has been developed with the specific demographics and geographic diversity of the Erie St. Clair LHIN in mind. Our LHIN encompasses the Municipality of Chatham-Kent, the County of Lambton, and the County of Essex.

Recognizing the diversity within each of the geographic communities, we propose an initial approach of establishing teams in each of the three geographic areas of Essex County, Lambton County, and the Municipality of Chatham-Kent. The teams will include health care providers and members of the community at large. They will be responsible for reviewing and analyzing the information regarding population needs and use of services, as well as identifying gaps and opportunities for improvement within their geographic area. The teams will help identify the health care priorities for their geographic areas. By working within these established boundaries, we believe that participants will see the discussions as pertinent to their communities. Ideally, this approach will maximize participation since people are more likely to become involved if they feel the issue is directly related to them. This approach could also alleviate some of the transportation concerns that may be a barrier to participation.

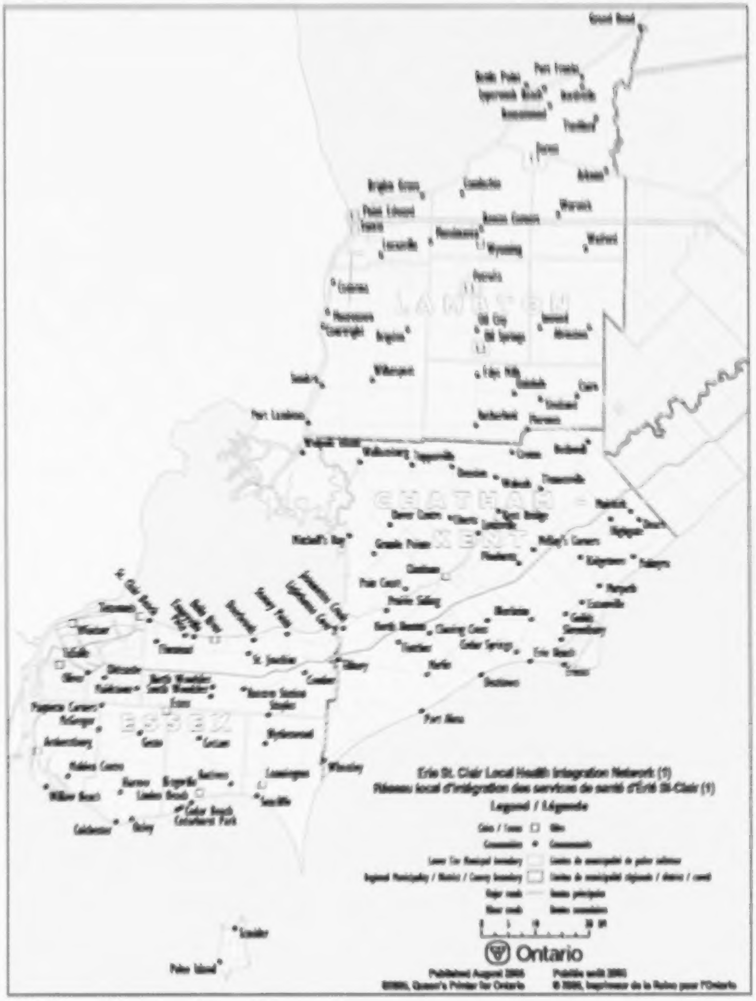
These community engagement areas have been identified to provide ease-of-access to engagement activities. However, it is understood there will be considerable flexibility in the engagement process and participants will not be excluded from consultation based on location.

The differences in population demographics will naturally lead to different health care needs and demands on the health care system. There may also be differences in the health status, access to services, and needs of these communities.

Health Care Matters will also address issues across county/municipal boundaries, since patients often cross boundaries to access care. By working across boundaries, there may be opportunities to learn about and possibly adapt solutions that other communities have developed to creatively address health care needs. For example, health sector-specific groups could be established across our LHIN.

There are also many existing groups and networks within Erie St. Clair that are focused on specific health issues — for example, mental health or palliative care. We intend to work with established groups/networks and to encourage the establishment of other networks to assist in identifying, developing and implementing strategies to improve health care.

About the LHIN


LAMBTON
CHATHAM - KENT
ESSEX
Erie St. Clair Local Health Integration Network (1)
Réseau local d'intégration des services de santé d'Érié St-Clair (1)
Legend / Légende
Ontario

Lambton County

- population declined 1.6% between 1996 & 2001
- median age is 3 years older than Ontario's
- 3 Aboriginal communities: Aamjiwnaang, Chippewas of Kettle and Stony Point, and Walpole Island

Chatham-Kent

- population declined 1.8% between 1996 & 2001
- designated bilingual under the *French Language Services Act*
- shorter than average life expectancy for Ontario
- 1 Aboriginal community: Moravian of the Thames

Essex County

- population grew by 7% between 1996 & 2001, compared with 6.1% for Ontario
- higher growth partially due to higher rates of immigration
- designated bilingual under the *French Language Services Act*

Total Population: 645,200

Evaluating ***Health Care Matters***

To ensure our community engagement framework meets its objectives, we will work to achieve each of the following goals as activities are designed and implemented:

> Participants have a clear understanding of the goals and objectives of the engagement, including the level and method of engagement.
>
> Participants are clear about the scope of the engagement and have a shared understanding of each others' roles, responsibilities and authority.

The engagement takes place when there is a real opportunity to influence the outcome.

Sufficient resources (time, budget, technology, etc.) and expertise are invested to achieve success.

Accessible opportunities are available that embrace the broad diversity of community interests.

The process is responsive to the input and needs of participants (access, information, etc.).

Relevant and credible information is gathered and distributed to participants in a timely manner and in a manner suitable to the intended audiences (language, culture, geography, etc.).

The communication leads to a mutual understanding of the process and an understanding and acceptance of outcomes.

Why LHINs are Good for Your Health

1. Patient-Focused Approach

Everything we do will be patient-focused to improve outcomes for them and their families. Every discussion we have, every decision we make, will centre around improving the health of the residents of Erie St Clair. After all…that's why ***Health Care Matters***.

2. LHINs are Local

The Erie St. Clair LHIN is governed locally by a Board of Directors with broad geographic representation from within the LHIN and a range of sector and skills experience relevant to our community. Our office, staff and leadership are local to our region.

3. Community Engagement is Critical

We are committed to community engagement. By ensuring two-way communication with you, our plans will reflect the needs and priorities of our LHIN. Seeking input, listening to our community, and building plans together gives everyone in Erie St. Clair a say in their health care.

4. Borders Do Not Mean Boundaries

LHINs are "boundaryless." Our "borders" allow us to look at the specific needs of our region. LHIN borders will not impact doctor referral patterns. Patients will continue to receive care from the doctor of their choice, even if that means travelling to another LHIN. By integrating our service plans within our region, everyone will become more aware of the choices that are available to them and should work with their doctors to determine the best location and doctor to meet their needs.

5. Best Practices Benefit Everyone

We can leverage the networks within our LHIN, and those that span across the province to other LHINs, to learn about and customize best practices that will work for our community. Sharing best practices across LHINs will assist in rapid deployment of new procedures to improve patient outcomes and increase efficiencies that reduce costs.

Next Steps

Health Care Matters is intended to be an inclusive strategy reaching out to as many partners as possible. We recognize that it will be a living document that will expand over time as the community provides ongoing feedback and the LHIN evolves and gains more knowledge and expertise.

We look forward to working with the community to make the changes that are necessary to improve the health care system so that it is responsive to patients and promotes the overall health of residents.

Your feedback and suggestions for improvement on the proposed Community Engagement Framework are welcome. A feedback form is included at the end of this document and we encourage you to complete and return it to us. Your input at this early stage of engagement is essential for ensuring our engagement process is as complete and inclusive as possible. With comprehensive insight from the community, we can create a tailored Integrated Health Services Plan for Erie St. Clair.

Alternatively, you can contact Gary Switzer, CEO, Erie St. Clair Local Health Integration Network at (519) 351-5677 *201 or 1-866-231-5446 or via email at gary.switzer@lhins.on.ca.

Thank you for your commitment to improving health care in our community.

Erie St.Clair
LOCAL HEALTH INTEGRATION NETWORK
RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
d'Érié St-Clair

HealthCare Matters

A Proposed Strategy to Engage Our Community

Feedback Form

Your feedback is essential to our engagement process. Please take a moment to provide us with your thoughts on the Erie St. Clair LHIN's proposed Community Engagement Framework ***Health Care Matters***. Your feedback will help us target our outreach and engage the community in meaningful discussions. Please note that all responses will be considered confidential. To subscribe to the LHIN's mailing list, please provide your contact information at the end of this form.

1. Please circle the response that most closely reflects your opinion:	Strongly Agree	Agree	Neutral/ Indifferent	Disagree	Strongly Disagree
a) The Community Engagement Framework's goals are appropriate.	1	2	3	4	5
b) The Community Engagement Framework's principles are appropriate.	1	2	3	4	5
c) The Community Engagement Framework provides an overview of various community engagement approaches.	1	2	3	4	5

2. How could this Community Engagement Framework be improved?

____

3. If you represent a health care services group or community organization, please indicate if the LHIN could share information through any of your organization's existing activities. Please circle all that apply:

Newsletter Regular or Special Meetings Email Distribution Conference Calls Other: ____________

4. Please rank your preferred method of receiving information from the Erie St. Clair LHIN (where 1 is the preferred method and 9 is your least preferred method).

Open Houses ______ Small Meetings ______ Direct Mail ______ Newsletter ______ Web site ______
Email Distribution ______ Radio ______ Cable TV ______ Newspapers ______

5. Please rank your preferred method of engaging with the LHIN (where 1 is the preferred method and 4 is your least preferred method).

Open Houses ______ Small Meetings ______ Surveys ______ Email ______
Other: ____

Contact information: Please check the community group which best describes you:

Residents/public ______ Clients/patients/consumers/advocacy groups ______ Transfer payment providers ______ Other service provider ______
Local networks ______ Stakeholders outside the LHIN geographic boundaries ______ Ministry of Health & Long-Term Care ______ Provincial networks ______
Other government ______ Other: please specify ______________________________

To subscribe to the Erie St. Clair LHIN's circulation list, please complete the following information:

Name: ______________________________
Name of Organization (if applicable): ______________________________
Street Address: ______________________________ City: ______________
Postal Code: ______________________ Email: ______________________

Thank you for your feedback. Your contributions to the development of an inclusive engagement process are essential for the development of a tailored Integrated Health Services Plan for Erie St. Clair. Please return this completed form by **May 19, 2006** via fax to 519-351-9672, or by mail to the Erie St. Clair LHIN 180 Riverview Drive, Chatham, ON N7M 5Z8. You may also email your responses to eriestclair@lhins.on.ca.

OUTCOMES OF COMMUNITY ENGAGEMENT CONSULTATIONS

APPENDIX D

OUTCOMES OF THE COMMUNITY ENGAGEMENT CONSULTATIONS

APPENDIX D

Background on Community Engagement

Community Engagement for the Erie St. Clair LHIN is guided by the framework document "Healthcare Matters." Healthcare Matters, a document distributed and subjected to public and stakeholder feedback, provided the strategic backdrop for how the LHIN would proceed with its community engagement activities.

Preliminary Experiences

Since the inception of the Erie St. Clair Local Health Integration Network (LHIN), the LHIN Leadership team participated in over 200 meetings, forums and provider board meetings over a seven month period. Stakeholders have been engaged in this process in order to create awareness and to introduce the Erie St. Clair LHIN mandate.

In the fall of 2004, the Ministry of Health and Long-Term Care asked a committee of local health and community leaders to report on local health care "priority issues." The preliminary priority issues that were identified in this are listed in the table below.

Priorities

Patient Care/Services

1. Improving Health Care and the Quality of Life for Seniors – through improved service provider integration
2. Health Sector Information and Referral Services
3. Integration of Children's Mental Health with Adult Mental Health
4. Cancer Integration Across the Continuum (Regional Cancer Plan)
5. Enhancing Integrated Pathways Across the Health Care Continuum
6. Improving Access to Primary Care through an Integrated Delivery System
7. Development of an Erie St. Clair Women's Health Network

Administrative Support Services

1. Integrated Back Office, including IT

2. Integrated Health Record
3. Local Governance Model
4. Integration of Mental Health and Addictions across the Continuum of Care, including Primary Care, Long Term Care and Chronic Disease Management

Feedback regarding the above priorities was solicited during Erie St. Clair LHIN round table meetings with community members, in order to shape the final integration directions established by the LHIN.

Community Engagement Forums (Round Tables)

A major phase of the community engagement process was the development of the community engagement forums (Round Table meetings) with the objectives of:

- Engaging with the public in their locale
- Informing and educating the community about the IHSP process
- Providing an overview of the overall population health of Erie St Clair residents
- Review the previously mentioned priorities report in order to determine if the previously articulated priorities (from 2004) were still valid
- Discuss issues and priorities from a community perspective

The open Round Table engagement sessions were also attended by health service providers, media, and in some cases Family Health Team and Community Health Centre leaders. LHIN staff were available to answer questions one-to-one. The sessions were held in advertised locations throughout the LHIN territory. To summarize:

- Four sessions were held in Lambton County with total attendance of 139
- Four sessions were held in Chatham-Kent with total attendance of 106
- Five sessions were held in Essex County with a total attendance of 147
- Two French language sessions were also held, one in Windsor and one in Pain Court with total attendance of 54 between the two sites
- One session was held at the Windsor Downtown Mission with a total attendance of 25
- One session was held at the Windsor Teen Health Centre with a total attendance of 14

The total attendance for all round table community engagements was 485 participants.

Further round table sessions are planned for local aboriginal communities, the hearing impaired community, and other targeted communities.

The following sections capture general comments and feedback from the community engagement efforts.

Results of the Round Table Community Engagement Forums

Exhibit I

Changing the Health care System (Top Priorities) – Chatham/Kent

(Includes priorities identified at Chatham, Ridgetown, Tilbury and Wallaceburg round table meetings)

What are the top health care priorities for your community?

- Recruitment and retention of professionals, including family physicians, specialists, nurses, nurse practitioners
- Improved working conditions for nurses (e.g. full-time positions and safer environments)
- Incentives for professionals to come here vs. the U.S.
- Need more simplified access to care (e.g. Better referrals and possibility of allowing discussion of more than one presenting health problem per visit to area physicians)
- Increase the number of Family Health Teams and integration of services and resources (eg. By building teams)
- Improved continuity of care
- Community Distress Line to provide information to people in the community
- Shift from system-focus to patient-focus
- Transportation
- Equal access to care in the catchment area (e.g. Doctors rotate to each town in the municipality)
- Ensure that there are no boundaries for referrals (e.g. to London)
- Decrease wait times (Emergency Room, primary care physicians, referrals to specialists, diagnostic tests, Long Term Care (LTC) homes)
- Increase in preventative medicine
- More research with respect to the condition of the environment and whether pollutants are causing health care concerns
- Cancer rates are a concern
- Improvement of mental health support and services in the community
- Increased community and health care provider education regarding mental health issues
- Long-term (3-5 year) transparent financial plan which is sustainable (increase efficiency and ensure Chatham/Kent is not under-funded, per capita)
- Ensure patient awareness of cost of services
- Integration of health records (Among other goals to ensure faster turn-around of results and consistency in paperwork)
- More comprehensive palliative care programs

- Improved accessibility to care in LTC homes
- Increased focus on Complex Continuing Care
- Maintenance of senior services
- Improved emergency services
- MRI and CT scan with sufficient staff to run 24 hours a day

Exhibit II

Changing the Health care System (Top Priorities) – Sarnia-Lambton

(Includes priorities identified at Forest, Grand Bend, Petrolia and Sarnia round table meetings)

What are the top health care priorities for your community?

- Reduce wait times (ER, primary care physicians, referrals to specialists, diagnostic tests, LTC)
- Recruit and retain health care professionals, including family physicians, specialists, nurse practitioners, and family health teams (perhaps offering incentives would be a method of doing so)
- Increased focus on preventative medicine
- Improved access to care (e.g. longer office hours, greater availability of equipment, etc.)
- Establishment of a central information office that can direct the public in accessing care
- Transportation and rural accessibility
- "Rural" must be identified as a specific area just as "Aboriginal" and "Francophone" needs have been identified
- Keep full-serviced hospital in rural area
- Improved integration and coordination of services
- Improved continuity of care
- Increased support for mental health services
- Ability to attend hospital of choice
- Increase in funding for LTC homes and home care
- Improved senior and homeless/low-income services
- Integrated health records information
- Reduce number of "non-emergency" visitors to Emergency Room
- Increase availability and support for latest cancer treatment drugs
- Infection control in hospitals
- Improved availability of palliative care
- Private hospital funding

Exhibit III

Changing the Health care System (Top Priorities) – Windsor-Essex

(Includes priorities identified at Amherstburg, Essex,
Leamington and Windsor round table meetings)

What are the top health care priorities for your community?

- More access to specialists in all areas, including: cardiology, psychiatry (particularly important), oncology, neurology, paediatrics
- Recruitment and retention of family physicians, nurses, nurse practitioners
- Improved working conditions for nurses (e.g. full-time positions) and increased education for nurse practitioners
- Incentives for professionals to come here vs. the U.S.
- Increase the number of physician training spaces available
- Transportation
- Decrease wait times (E.R., Urgent Care Clinics, primary care physicians, Cancer Clinic, referrals to specialists, diagnostic tests, LTC)
- Greater accessibility to diagnostic services and tests
- Develop a funding model and acquire an equal share of health care funding based on population
- Accountability
- Decrease waste in the health care system (e.g. use existing funds more efficiently, do not provide home care services that are not currently needed, do not provide excess medication)
- Develop best practice guidelines
- Pandemic planning
- Focus on preventative health care
- More research required on pollution and its effects on health care (and improving condition of the environment)
- Provide information sessions locally regarding disease prevention, system navigation, etc.
- Central number to call to speak to a person (not voicemail or web-based) in order to determine where to access the type of care that is needed (Educate the public on how to use the system as it is intended to be used)
- Education of the public with respect to the cost of services, and the status of health and health care
- Standardized health record that is transferable between different providers
- More holistic approach to care; create care paths across sectors
- Care should be patient-focused (More autonomy for staff to make individual care plans)
- Improved integration of follow-up care (e.g. develop standard procedures)

- Additional support for home care (including for families with children with complex health care needs)
- Increase palliative care resources and educate workers with respect to pain management
- More LTC and respite beds
- Supportive housing as alternative to LTC
- Increase the number of specialized residences for the needs of the community (e.g. for the mentally ill and disabled persons)
- Improve Alternate Level of Care numbers
- Attach urgent care clinics to Emergency Rooms in order for triage to send less urgent cases there
- Improved cardiac services
- Acquired brain injury for paediatrics non-existent, and for adults, minimal
- Mental health training for Long Term Care homes and Emergency Rooms.
- Better integration of mental health services
- Improved integration of mental health patients into the community (coordinate hospital with CHAN and local out-patient services)
- Improved child/adolescent mental health services
- Improved mental health geriatric assessment program
- Increased involvement of families in mental health care
- Access and continuum of care in area of problem gambling and other addictions (e.g. pilot residential program gambling – will it be sustained?)
- Services to homeless population
- Mandate changes in OHIP (optometry, physiotherapy, chiropractic and massage therapy)
- Improved services for newcomers to Canada
- Re-evaluation of the "Interim Federal Health Program"

Exhibit IV

Changing the Health care System (Top Priorities) – French Language

(Includes priorities identified at Pain Court and Windsor)

The French language sessions were facilitated by a French Language facilitator and were delivered in French. Note: The translated bullet points and narrative are provided directly from the facilitator.

What were the top Health Care Priorities for your community?

- Improved coordination of efforts and strategies targeting the overall Francophone community
- Plan, develop and implement (integrated delivery) services in French across the system
- Establish a continuum of mental health services in French (including addictions, promotion and prevention)

for children and youth. This priority also referred to the need to provide services for parents of children and youth who are using drugs and alcohol

- Services for the elderly across all settings – particular challenges were identified in long term care, home care and acute care
- Residential services for youth
- Target children and youth in schools – i.e. health promotion, prevention in French. Participants also identified this intervention as a strategy for encouraging youth to consider a career as a health professional in French
- Ensure that printed matter is available in both French and English including information pamphlets, forms, and consent forms
- Awareness campaign regarding the health needs of Francophones in Ontario
- Reduce wait times to improve access to critical services and the Emergency Room
- Increase the availability and access to diagnostic equipment
- Transportation

The narrative below was provided by the French language facilitator in order to provide the LHIN with the context and the depth of the feedback from the sessions.

Human Resources

- Recruit and retain health professionals able to provide services in French. Participants acknowledged the lack of francophone health professionals as an issue throughout the province, but felt the issue was exacerbated in southern Ontario. As a result, it is not uncommon for services to be offered in English in Francophone environments such as schools
- Suggestions for action included the use of incentives, the use of broad and intensive recruitment strategies (across the province, nationally, and internationally), and increased training opportunities in French
- Need for allied health professionals able to offer services in French – OT, PT, social workers and speech therapists to work across the continuum and more specifically in schools with children and youth
- Increase the number of family physicians
- Provide learning opportunities for health professionals regarding the importance of providing health services in French (regardless of the bilingual capacity of the client) and the health status of the Francophone community of the Erie St. Clair LHIN catchment area

Improved Access

- The lack of access is compounded by the absence of French language health services across the continuum. As a starting point, participants proposed that a French language referral centre be established. The centre would also play a role in system navigation

- Building on the aforementioned priority was the need to establish a Francophone community health centre that would offer services in French to the entire community. It would also provide collaboration and interdisciplinary opportunities within a patient centred model of care. Furthermore, this health centre could serve as a potential model for the delivery of French language services in other health and social service areas
- Develop and implement a media campaign and other strategies (signage, pamphlets, radio/television public service announcements) designed to increase the awareness and use of existing French language health services
- Increased access to Francophone health professionals, 24 hours per day, by looking at improved deployment strategies

Increased focus on health promotion and disease prevention

- Develop prevention strategies targeting specific health problems in the Francophone community (i.e. excess weight and obesity). Strategies would be developed and implemented using francophone cultural terms of reference

Improved information and data – a focus on quality and accountability

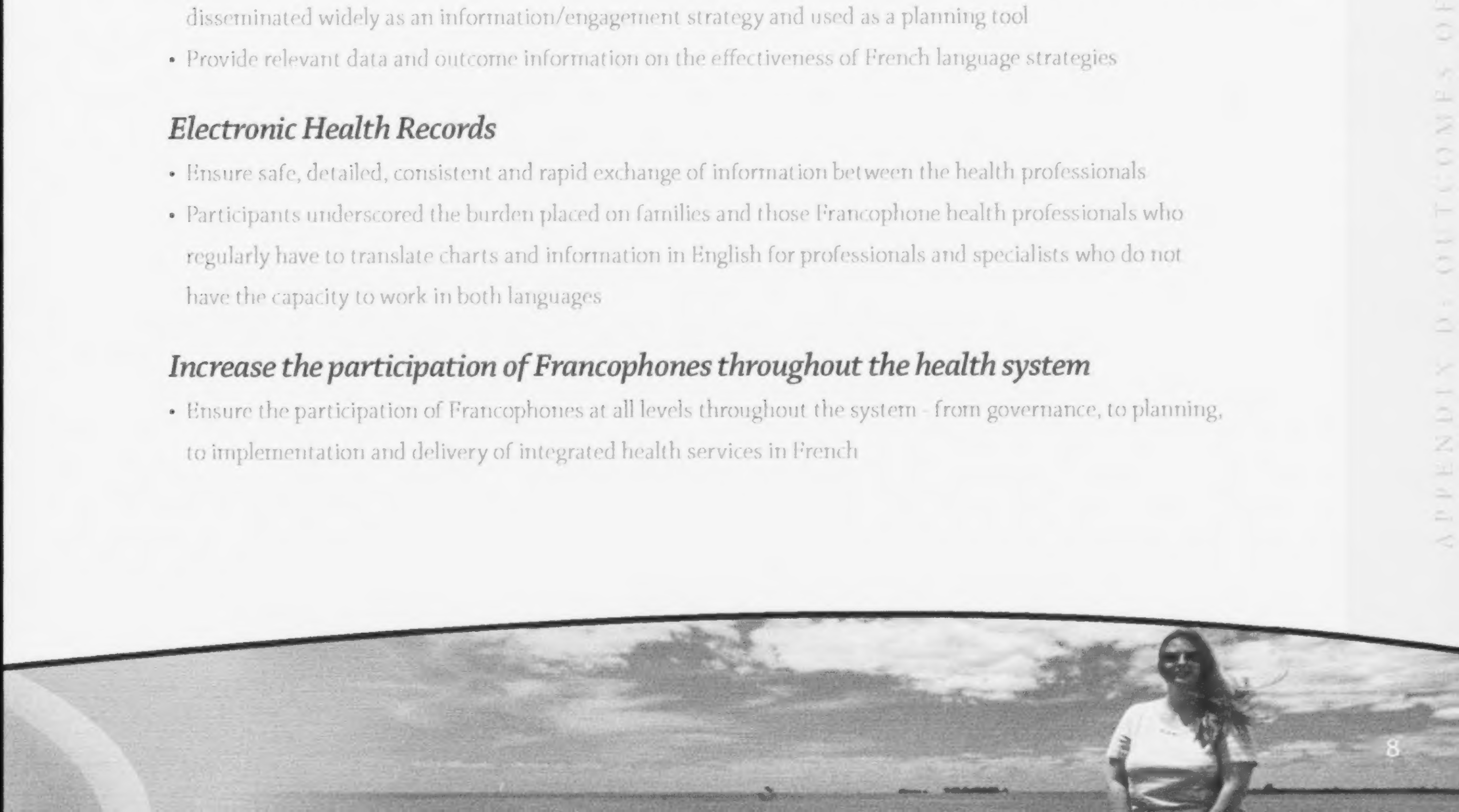
- Provide improved access to information about the health system overall to the general population (this was identified as a strategy that would not only improve the publics understanding of system issues but also engage them in developing appropriate solutions)
- Develop a profile of the health status of Francophones across the Erie St. Clair catchment area that could be disseminated widely as an information/engagement strategy and used as a planning tool
- Provide relevant data and outcome information on the effectiveness of French language strategies

Electronic Health Records

- Ensure safe, detailed, consistent and rapid exchange of information between the health professionals
- Participants underscored the burden placed on families and those Francophone health professionals who regularly have to translate charts and information in English for professionals and specialists who do not have the capacity to work in both languages

Increase the participation of Francophones throughout the health system

- Ensure the participation of Francophones at all levels throughout the system - from governance, to planning, to implementation and delivery of integrated health services in French



Focus on Primary Care

- Increase the number of community clinics and/or use Francophone schools as an appropriate setting for primary care interventions for the community
- Establish a Family Health Team that would serve the Francophone community

Exhibit V

Downtown Mission Consultation Forum - Windsor

What do you need from the health care system/LHINs?

- Need faster services: CAT Scan, OHIP card processing, doctor consultation
- Need of more professionals: doctors, physiotherapists, chiropractors, nurses, doctors and nurses to handle hearing impaired patients
- Need to reduce: waiting times, the cost for diabetic treatment (foot care)
- Improve: nurses retention, transportation to and from hospitals, after care, first interface with homeless (i.e. ER, between patient and clinicians, etc.), communication between patients and doctors, waiting times, in home care
- Need to eliminate: cost for ambulance service, cost of transportation to hospitals
- Need to create: OHIP coverage outside of the province/country, cardiac assistance program, subsidized housing, funding for personal care

Other comments

1. Closing hospitals causes problems
2. Doctors need more schooling and are not compassionate
3. Don't want more pills, want more care
4. Becoming a drain on the health system
5. Bad advice from home care workers

What obstacles do you deal with when you try to access health care?

- Money for prescription drugs
- Money for health care services
- Transportation
- Home care assistance
- Housekeeping assistance (Can't get a homemaker)
- Assumption of addiction
- Lack of examinations, just script
- Care for elderly

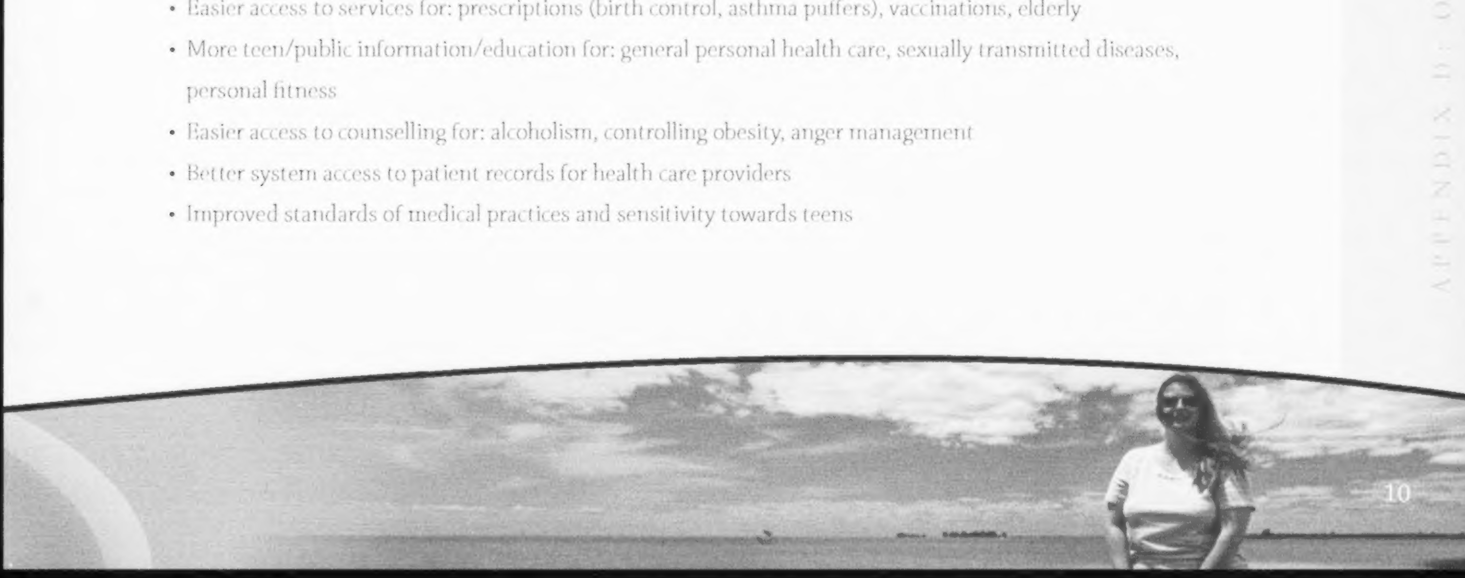
- People without OHIP coverage, should have a reduction on taxes
- Can't get information on home care
- Transportation to get to treatment
- Better home care for heart disease
- If no OHIP card, i.e. moved, lost or stolen, no service (need to improve OHIP cards system)
- Doctor sees you for only one issue at a time
- More time with doctors to explain medication, disease, more drug information
- A better understanding by caregivers that an impairment affects the whole body
- Not enough X-Ray facilities
- Psychologist not covered by OHIP
- Subsidy for dental care
- Informed consent vs the doctor consequences
- Patient rights
- Patient presenting with symptoms vs cost of exploration
- Cost of procedures (i.e. hearing, blood test)
- Long distance to hospitals
- Lack of access for hearing impaired
- Cuts to disability cheques affect their ability to pay for health care

Exhibit VI

Teen Health Centre Consultation Forum - Windsor

Summary of Top Health Care Needs

- Easier access to health care specialists: family doctors, dentists, chiropractors, counsellors for teens (see below)
- Shorter waiting times for serious problems/injuries
- Easier access to services for: prescriptions (birth control, asthma puffers), vaccinations, elderly
- More teen/public information/education for: general personal health care, sexually transmitted diseases, personal fitness
- Easier access to counselling for: alcoholism, controlling obesity, anger management
- Better system access to patient records for health care providers
- Improved standards of medical practices and sensitivity towards teens



Top Health Priorities

The teen session participants were broken into groups in order to identify top health priorities. The comments are summarized in the below table.

Group One	Group Two	Group Three
Taxes might go up	More health-related information	Easy access to health information
More clinics, hospitals, ERs, splitting 'urgent' vs. 'ER' care	Cut down ER wait times	Confidentiality for teens
More doctors (residents and transfers)	More facilities for teens	Sympathy towards teens
Better technology, more equipment	Put patient medical profiles on their OHIP cards	Easier access to fill prescriptions
Integration of networks	More family doctors	Increase awareness of health programs for teens
Faster ambulance service	Teen financial support for health care prescriptions	Provide financial assistance for low-income homes
More counselling services for youth	Expand family doctor practices to include other services (counselling)	Better/more technology
Better mental health care system	More counsellors	Reduce waiting times
Have doctors, nurses remove stereotypes about teens		More doctors/nurses
More privacy for patients		Improved transportation to hospitals

Health Care Challenges that Teens Face

The teen participants were asked to identify the key health care challenges that they experience. The below list summarizes the findings.

- Finding a doctor who knows them and their medical histories and is as supportive about their good health as treating their illnesses
- Finding health care providers who do not prejudge, or have stereotypical views of teens
- Keeping medical care confidential, even from parents
- Finding a family doctor
- Getting ready access to health care providers for general check-ups
- Getting accessible, low-/no-cost transportation to health services

Finding information about

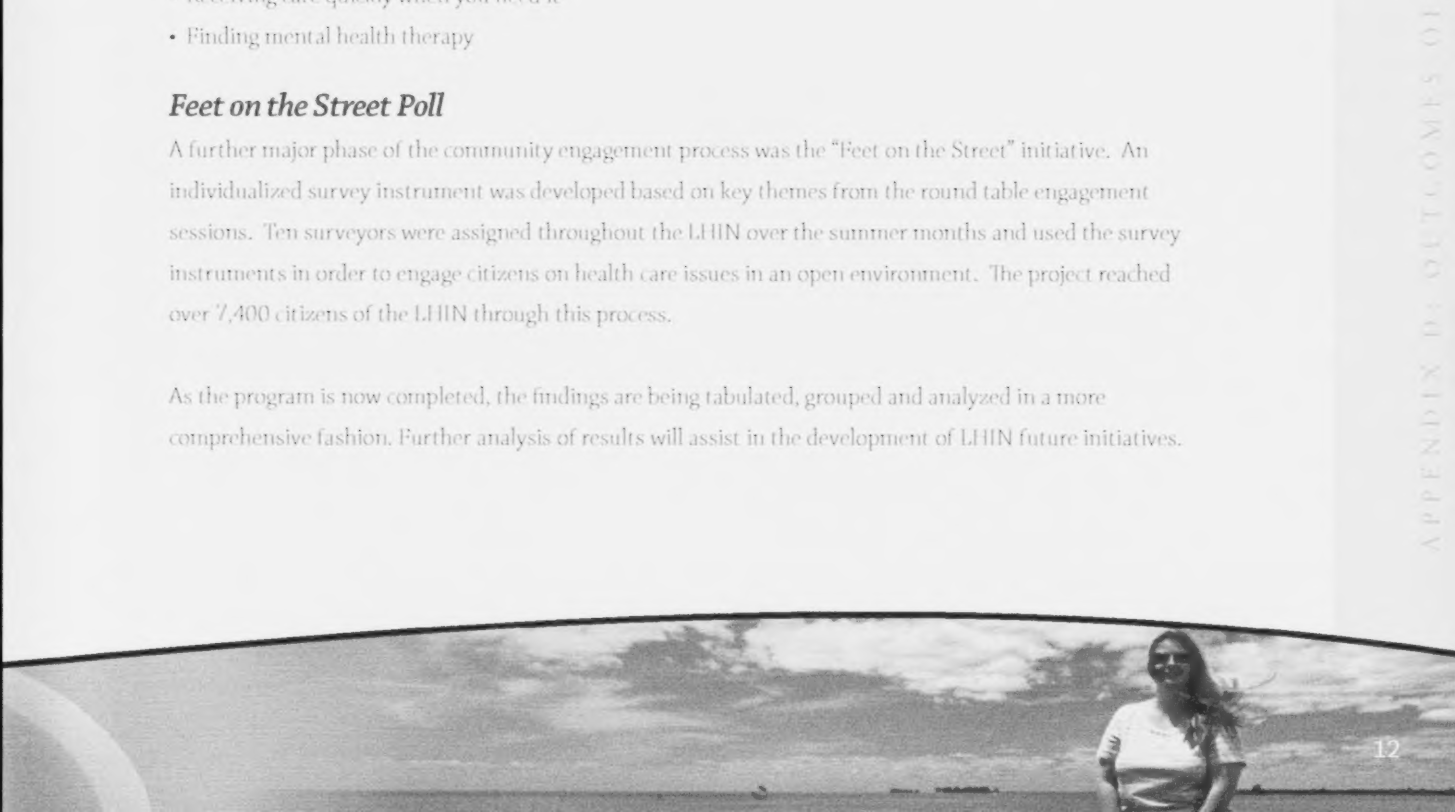
1. The health care system – what's available for teens, who to contact
2. Sexually transmitted diseases
3. My own health, and why/when I would need to see a doctor
4. Prenatal care

- Long waiting times
- The high cost of prescription medications
- Receiving a consistent level of care by specialists
- Limited number of counsellors who understand teens
- Receiving care quickly when you need it
- Finding mental health therapy

Feet on the Street Poll

A further major phase of the community engagement process was the "Feet on the Street" initiative. An individualized survey instrument was developed based on key themes from the round table engagement sessions. Ten surveyors were assigned throughout the LHIN over the summer months and used the survey instruments in order to engage citizens on health care issues in an open environment. The project reached over 7,400 citizens of the LHIN through this process.

As the program is now completed, the findings are being tabulated, grouped and analyzed in a more comprehensive fashion. Further analysis of results will assist in the development of LHIN future initiatives.



Public Poll Results: Health Care Priorities (Summer 2006)

Keep family physicians, specialists and other health care providers	75
Get access to care in your local community	44
Improving the mental health care system	24
Health record accessible by all health care providers	22
Transportation to health care services	21
Increased attention to health promotion/prevention	20
Help with information/navigation through the system	12

Lessons Learned

The IHSP community engagement process was an enlightening experience for all those involved. Ongoing consultation with stakeholders and providers has provided insight and clarity about the current activities and unique aspects of the local health care system. Below is a brief list of some of the key learnings to this point in the process.

Focus primarily on key data areas as stimulus for improvements

As the IHSP process evolved, the LHIN and its planning process was overwhelmed with descriptive data. The LHIN planning team noted that as it focused on selected key data points (e.g. ER non urgent visits) and engaged community and stakeholders on the interpretation of the data point, comprehensive understanding and action orientated priorities evolved.

Community Engagement Round Table Processes

Community participants were asked to record and refine the key priorities for health care. This facilitated process enabled participants to focus on key processes at the session and also provided the basis for thoughtful rationale to support claims. Further, afternoon community engagement sessions did not work well in the rural Erie St. Clair communities. Attendance was better at evening sessions.

Rural focus

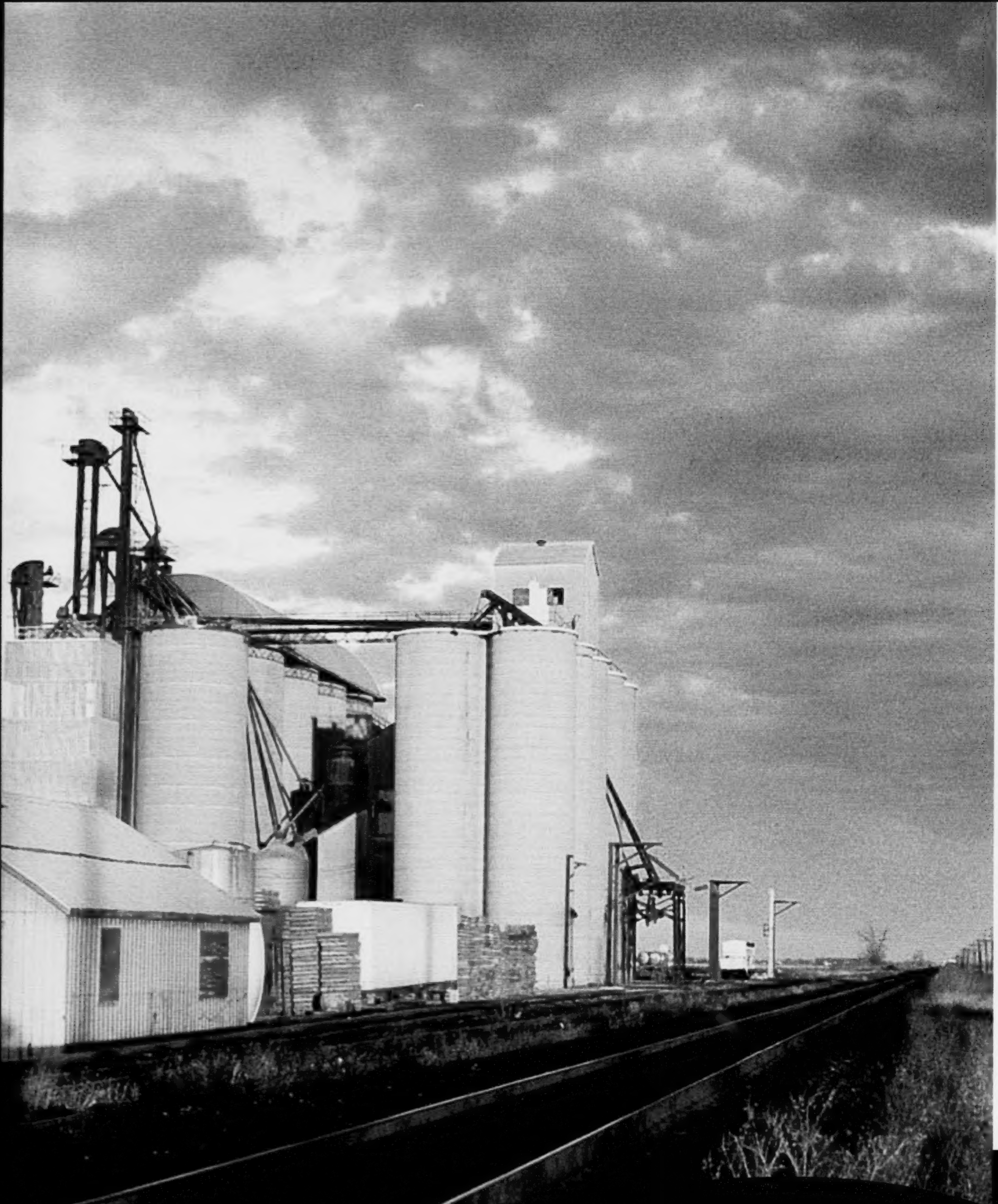
For many of the participants, this form of engagement was the first time that they had an opportunity to participate in a local health care planning process. Great suggestions came from rural area sessions that highlighted how an integrated system could evolve.

Community Health Centre Scope

CHC's are an excellent source of primary care level information and an example of a synergistic system. An example of a synergistic partnership was found at the Kettle Point and Stony Point aboriginal reserve and the Community Health Centre satellite location on the reserve.

Board member involvement

The presence of board members at community engagement sessions added legitimacy to the process. The presence gave the public opportunities to interact with the Board and reinforced for the public the fact that the board heard the comments directly.



READINESS REPORTS

APPENDIX E

APPENDIX

READINESS REPORTS

APPENDIX E

Part 1. Erie St. Clair e-Health Strategy

Part 2. Erie St. Clair Wait Times

eHealth Strategic Plan

Erie St. Clair Local Health Integration Network

Executive Summary Presentation

September 15th, 2006

Updated September 22nd, 2006

Executive Summary Presentation Agenda

1. Welcome and Introduction	Sharon Pfaff & Betty Kutcha
2. Meeting Objectives	Rhonda Chou
3. eHealth Strategic Plan Summary eHealth Advisory Group Membership Current State Analysis SWOT Analysis Vision, Strategic Directions Guiding Principles 5 Year Strategic Roadmap Governance Critical Success Factors Action Plan	Rhonda Chou
4. Action Items and Wrap Up	Sharon Pfaff
5. Closing Remarks	Gary Switzer

We hope to achieve the following objectives in today's meeting

- **Endorse the 5-Year Strategic Roadmap**
  - Inclusive of LHIN priorities and Provincial eHealth initiatives
- **Endorse in principle the draft Memorandum of Understanding**
- **Endorse the recommendation to retain the existing eHealth Advisory Group for the purpose of overseeing the transition from planning to execution**
- **Endorse the establishment of the LHIN eHealth Strategic Council**
- **Endorse the proposed Action Plan**

An eHealth Advisory Group was established and charged with the development of the LHIN eHealth strategy

Sector	**Members**	**Organization**
Community Agencies	Chris Biggs Sondra Callum	Bayshore Canadian Red Cross
Community Care Access Centres (CCACs)	Darren Brown Vicki Harkness	WE CCAC CK/SL CCAC
Community Health Centre (CHC)	Kathy Bresett	North Lambton CHC
Hospitals (Acute, Rehab and Complex Continuing Care)	Paul Audet Gary Higgs Nancy Snobelen	HDGH BWH Rehab & CCC - CKHA
IHSP Liaison	Ralph Ganter	LHIN
LHIN eHealth Lead	Sharon Pfaff *(chair)*	CHIS
Long Term Care	Ann Currie	PC Lodges
Mental Health and Addictions	Bill Marcot	Mental Health - WRH

Why should Erie St. Clair LHIN move forward with an eHealth Strategy?

Improving Client Care & Safety	• Timely access to critical client information and services • Reduce risk of errors through access to client information via a clinician portal • Improve client safety through the use of IT tools that address quality and safety issues
Empowering Clients/Public/ Providers	• Provide health promotion and prevention tools to both clients and providers in shifting the focus from curing to preventing • Develop client portals, chronic disease management programs, and self-diagnosis tools to empower clients to manage their own health care
Connecting to Community Care	• Increase access to integrated client information across the continuum of care • Improve communication and integration of health care communities
Meeting Ontario's Health Care Transformation Agenda	• Consistent with Infoway's Interoperable EHR program • Consistent with Ministry of Health and Long Term Care (MOHLTC) initiatives including Wait Time Information System and provincial EMPI initiative • Align with the Provincial LHIN eHealth Council agenda • Support MOHLTC transformation agenda and Family Health Team initiatives
Improving Process Efficiency	• Maximize staff time and increase worker efficiency • Improve information and system management, resulting in reduced administrative time and costs • Help to mitigate health human resource shortages (particularly physicians and specialists) • Reduce the duplication of services such as lab test, x-rays, etc

Various inputs received during the current state analysis set the foundation for the LHIN eHealth Strategy

Stakeholder Engagement Workshop:

- 60+ participants from across sectors
- Asked to describe the service delivery needs within their sector
- Asked to identify solutions to address the service delivery needs

Identified priority service delivery needs to be addressed

Executive Interviews (CEO/EDs/CIOs):

- 16 one-on-one interviews completed
- 1 hour spent with each participant to understand their views on eHealth in the Erie St. Clair LHIN

Informed guiding principles and main strategic directions

Strategic Document Review:

- Continuing Care eHealth Strategy
- Erie St. Clair LHIN Integrated Health Services Plan Draft Priorities
- Ontario Hospital Association Electronic Health Record Readiness Survey

Provided inputs to the strategic plan

IM/IT Survey:

- Sent to LHIN organizations where an e-mail address was available
- 22 responses were received: 5 acute care facilities and 17 non-acute care facilities
- Questions were targeted to areas where information gaps were identified

Resulted in a general understanding of the current state of IM/IT investment across the sectors

The following "clinical and business needs" were identified and prioritized during the stakeholder engagement workshop

The needs are listed below in general order of how they were ranked*

High ↑

- Information Sharing across Organizations and Sectors
- Improved Connectivity and Infrastructure
- Supporting Business Intelligence and Strategic Decision Making
- Improving Operational Efficiency
- Improving Communication
- Engaging Clients/Public
- Focusing on Staff Education, Retention and Resourcing

Low

*There was not a material difference in rankings from perspective, role or sector

A SWOT analysis framework was used to synthesize the findings from the assessment of the current environment (workshop, interviews, survey, documents)

Strengths

- Existing vehicle for delivering shared IM/IT services: Consolidation Health Information Services - CHIS
- Common Clinical Management System for Family Health Teams
- Common Clinical Management System for Community Health Centres
- Robust consumer portal available for use (Centre for Smart Community Innovation Consumer Portal)
- Comprehensive inventory of health care service providers across Ontario available to CCACs (I&R - Information and Referral Database)
- An innovative community scheduling system deployed at Chatham Kent Health Alliance and Windsor Regional Hospital
- Spirit of collaboration (eg. deployment of SolCom across 4 hospital sites)
- High satisfaction with the Clinical Portal implementation at Chatham Kent Health Alliance; potential to leverage the same clinical portal solution
- Success in change management at the CCACs; may be able to leverage the CCAC change management model
- South Western Ontario PACS/Diagnostic Imaging Initiative
- HDGH has experience in LEAN management

Weaknesses

- There is little infrastructure between organizations; referrals between organizations are largely manual (for example, CCACs are sending referral information mainly via fax machines)
- There is no feedback loop when clients are transferred (for example, when a CCAC client is hospitalized, the hospital record is not sent back to the CCACs/LTCs)
- Acute care hospitals have made a greater investment in IM/IT than the community agencies
- Long term care and mental health organizations vary greatly in starting positions in terms of IM/IT (resources, infrastructure, and budget)
- There are limited IM/IT resources in the community sectors
- Collaboration on IM/IT initiatives tends to occur within discreet groups
- Clinician expectations of IM/IT vary greatly across the LHIN

Opportunities

- Leveraging partnerships with neighbouring LHINs
    - Grand River Hospital – myCARE Client Portal
    - London communities – theHealthline.ca – a list of health care services for the region
    - Waterloo Wellington LHIN - CHIN project – a secure information transfer system
- Greater, more inclusive collaborative efforts on IM/IT projects
- Alignment with provincial eHealth strategy and initiatives
- Integration across the continuum of care, particularly among the community health sectors
- Leverage funded provincial initiatives to bring additional value to the LHIN
- Learn from other provinces who adopted regionalized models before Ontario

Threats

- Low physician to patient ratio
- Uncertainty regarding the CCAC consolidation
- There is not a defined funding methodology to support LHIN eHealth initiatives
- Resource constraints and competing demands, worsened with recent mandatory provincial project
- State of readiness and capacity for change

IM and IT have been identified as critical enablers in supporting the Integrated Health Services Plan. The development of the eHealth strategy was coordinated and aligned with the IHSP

- The LHIN's **strategic priorities** as identified in the IHSP are:
  - Support chronic disease management
  - Improve system navigation (for example, a directory of health care service providers across the LHIN for public use)
  - Emphasize health promotion and prevention (for example, provide education on health care issues such as public health, depression, obesity, and heart disease)
  - Reduce dependencies on hospitals
  - Focus on access issues including critical care access
  - Evaluate opportunities for back office system integration
  - Develop strategies for human resources recruitment and retention
  - Supporting care at home

- Specific **critical success factors** identified in the IHSP include:
  - Increasing access
  - Increasing quality
  - Developing system thinking
  - Developing a sustainable system

The Advisory Group established a set of principles to guide the development of the LHIN eHealth strategy

- We will recognize that we are not "starting from scratch"; we will leverage existing investments, initiatives, and expertise where appropriate and optimize current organizational strengths, both within and beyond Erie St. Clair LHIN
- We will engage clinicians and physicians in the development and execution of the strategy
- We will ensure alignment and identify gaps with the provincial eHealth strategy
- Our prime focus will be on regional opportunities and are supported by individual organization interests
- eHealth initiatives will be based on best practice and the use of common standards
- The eHealth Strategic Plan will balance opportunities for early wins with initiatives leading to the achievement of our long-term vision
- We will put the client first when designing information management strategies
- We will ensure all decisions are based on a business case and are affordable and sustainable
- We will choose solutions that are adaptable and will allow integration with other LHINs
- We need to trust and respect each other and the unique needs of each organization

-Through collaboration, we become better-

The Advisory Group reviewed all findings and inputs and developed the eHealth vision and strategic directions

Ontario's Health Care Vision

"A health care system that helps people stay healthy, delivers good care when they need it, and will be there for their children and grandchildren"

Ontario's e-Health Vision

"By 2015, Ontario's health system is the safest, highest quality, and most sustainable in Canada because people have the right information, at the right time and in the right place. Ontarians are confident that:

1. They have the information they need to make decisions about their health and health care;
2. Providers and clinicians are freed to focus on timely and highest quality care; and
3. Government and LHINs ensure an accountable, equitable, effective and efficient health system

Erie St. Clair LHIN eHealth Vision

~ A health system that empowers its people (physicians, providers public) to achieve a healthy lifestyle~

eHealth is used to provide quality care and ensure people have access to a sustainable system

Strategic Directions

1. Improve Provider Efficiency by Sharing Information and Integration of Services
2. Improve Management and Prevention of Chronic Diseases
3. Empower Clients
4. Improve Operational Efficiency

Strategic Direction #1:

Improve Provider Efficiency by Sharing Information & Integration of Services

This priority focuses on making it easier to practice good medicine and sharing information across the continuum of care.

Improved access to health care information and services by providers when they need them is critical to a well functioning health system.

Goals
Improve information sharing between providers across the health care spectrum
Improve provider awareness of the services within the LHIN
Support physicians/providers with the implementation of an integrated Clinical Management System (CMS) to allow for timely access to client records and improve client safety
Integrate the Electronic Medical Record (eg. CMS) and Electronic Patient Records (EPR) into an Electronic Health Record
Improve ability to navigate health care information across the continuum of care
Support Erie St. Clair LHIN business strategies of access, efficiency and coordination
Initiatives
Develop an infrastructure architecture to support eHealth Strategy Initiatives
Deploy secure email to all LHIN organizations
Automate and improve integration with physician offices and Family Health Teams
Automate and standardize the referral information management process
Establish a regional clinical portal
Develop an online inventory of health care services (*this initiative has 2 audiences: provider and public)*

Strategic Direction #2:
Improve Prevention & Management of Chronic Diseases

Enhancing the prevention and management of chronic diseases will support seamless and integrated care and improve the health outcomes of clients with chronic diseases. This will involve focusing on empowering individuals, sharing accountability and enabling proactive care delivery through the development of a Chronic Disease Prevention and Management Program

Goals
Support the management of chronic diseases through the chronic disease registry and client portal
Improve the process for managing clients according to evidence based guidelines and incorporating health promotion tools
Initiatives
Provide IM/IT support to a Chronic Disease Prevention and Management Program

Strategic Direction #3:
Empowering Clients

Empower clients and the public to make informed decisions by providing appropriate tools and timely information.

Goals
Improve public awareness of the services within the LHIN and how to access them
Improve client access to their health information to better manage chronic diseases
Initiatives
Implement a client portal* (initially will include information for chronic diseases and may expand to include other health information including health promotion)
Develop an online inventory of health care services; potentially through a consumer portal** (*this initiative has 2 audiences: provider and public)*

Definitions:

Client Portal: *Portal for people currently engaged in the care process*

****Consumer Portal***: *Portal for the general public; may or may not be engaged in the care process (eg. a community portal)*

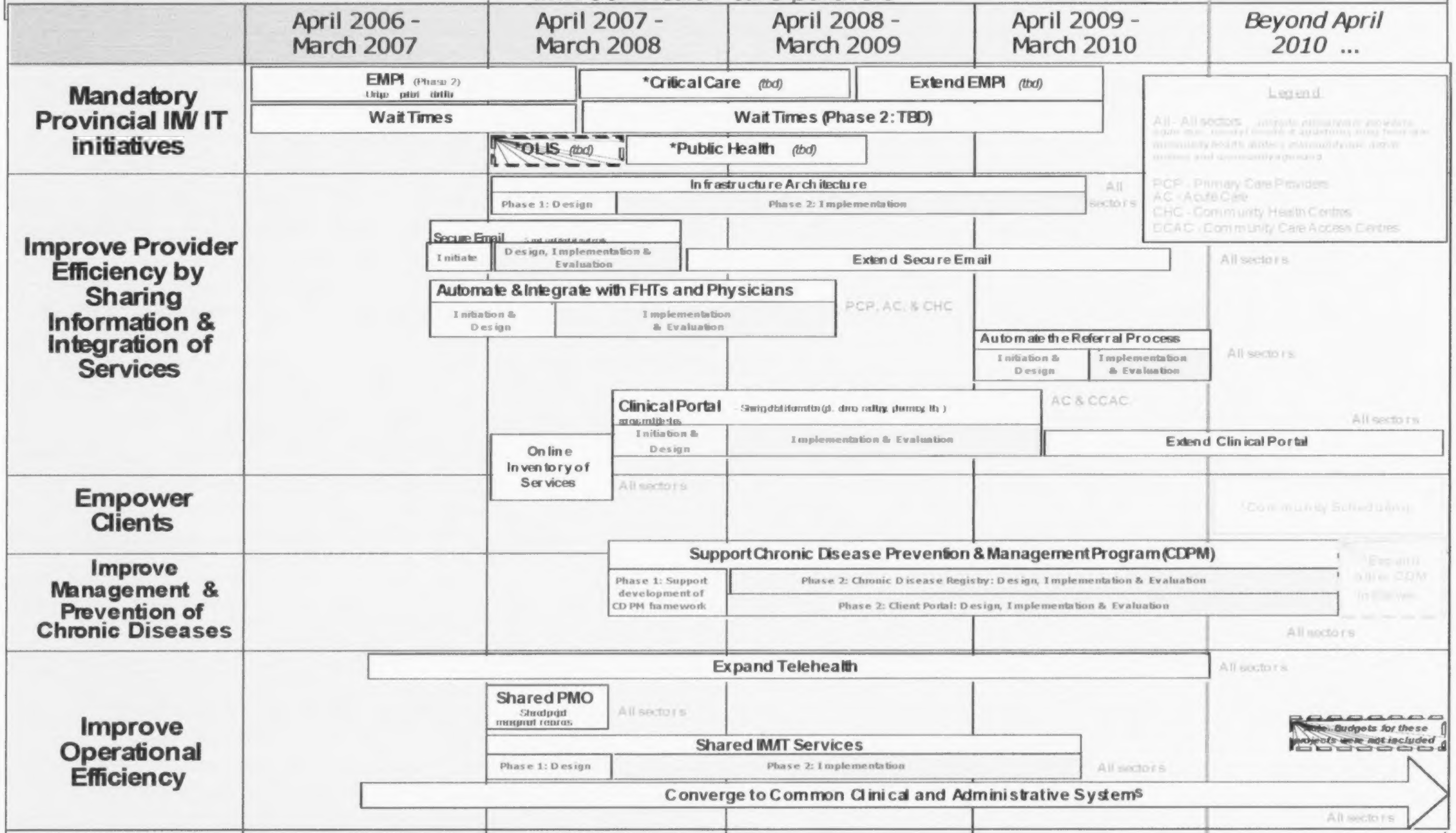
Strategic Direction #4:
Improve Operational Efficiency

Improve operational efficiency and identify potential areas for collaboration across the LHIN to optimize the use of resources

Goals
Optimize the use of resources (financial and human)
Achieve more value for a given level of spending
Deliver eHealth strategic projects on schedule and within budget and with predefined outcomes achieved
Achieve best practice methodologies on project management and change management
Initiatives
Develop a shared IM/IT support services group
Develop a shared Project Management Office
Expand Ontario Telehealth Network to address clinician/specialist demands
Converge to common clinical and administrative systems

This roadmap depicts the planned implementation and financial implications of the LHIN's 5 year strategy. This plan should be revisited annually to ensure its ongoing appropriateness and accuracy

We envision a health system that empowers its people to achieve a healthy lifestyle. We strive to provide quality care and ensure our people have access to a sustainable system through using eHealth to link our health care partners


April 2006 - March 2007
April 2007 - March 2008
April 2008 - March 2009
April 2009 - March 2010
Beyond April 2010 ...
Mandatory Provincial IM/IT initiatives
EMPI (Phase 2)
*Critical Care (tbd)
Extend EMPI (tbd)
Wait Times
Wait Times (Phase 2: TBD)
*OLIS (tbd)
*Public Health (tbd)
Legend
All - All sectors
PCP - Primary Care Providers
AC - Acute Care
CHC - Community Health Centres
CCAC - Community Care Access Centres
Improve Provider Efficiency by Sharing Information & Integration of Services
Infrastructure Architecture
Phase 1: Design
Phase 2: Implementation
All sectors
Secure Email
Initiate
Design, Implementation & Evaluation
Extend Secure Email
All sectors
Automate & Integrate with FHTs and Physicians
Initiation & Design
Implementation & Evaluation
PCP, AC, & CHC
Automate the Referral Process
Initiation & Design
Implementation & Evaluation
All sectors
Clinical Portal
Initiation & Design
Implementation & Evaluation
AC & CCAC
All sectors
Extend Clinical Portal
Online Inventory of Services
All sectors
Empower Clients
Community Scheduling
Improve Management & Prevention of Chronic Diseases
Support Chronic Disease Prevention & Management Program (CDPM)
Phase 1: Support development of CDPM framework
Phase 2: Chronic Disease Registry: Design, Implementation & Evaluation
Phase 2: Client Portal: Design, Implementation & Evaluation
All sectors
Improve Operational Efficiency
Expand Telehealth
All sectors
Shared PMO
All sectors
Shared IM/IT Services
Phase 1: Design
Phase 2: Implementation
All sectors
Note: Budgets for these projects were not included
Converge to Common Clinical and Administrative Systems
All sectors

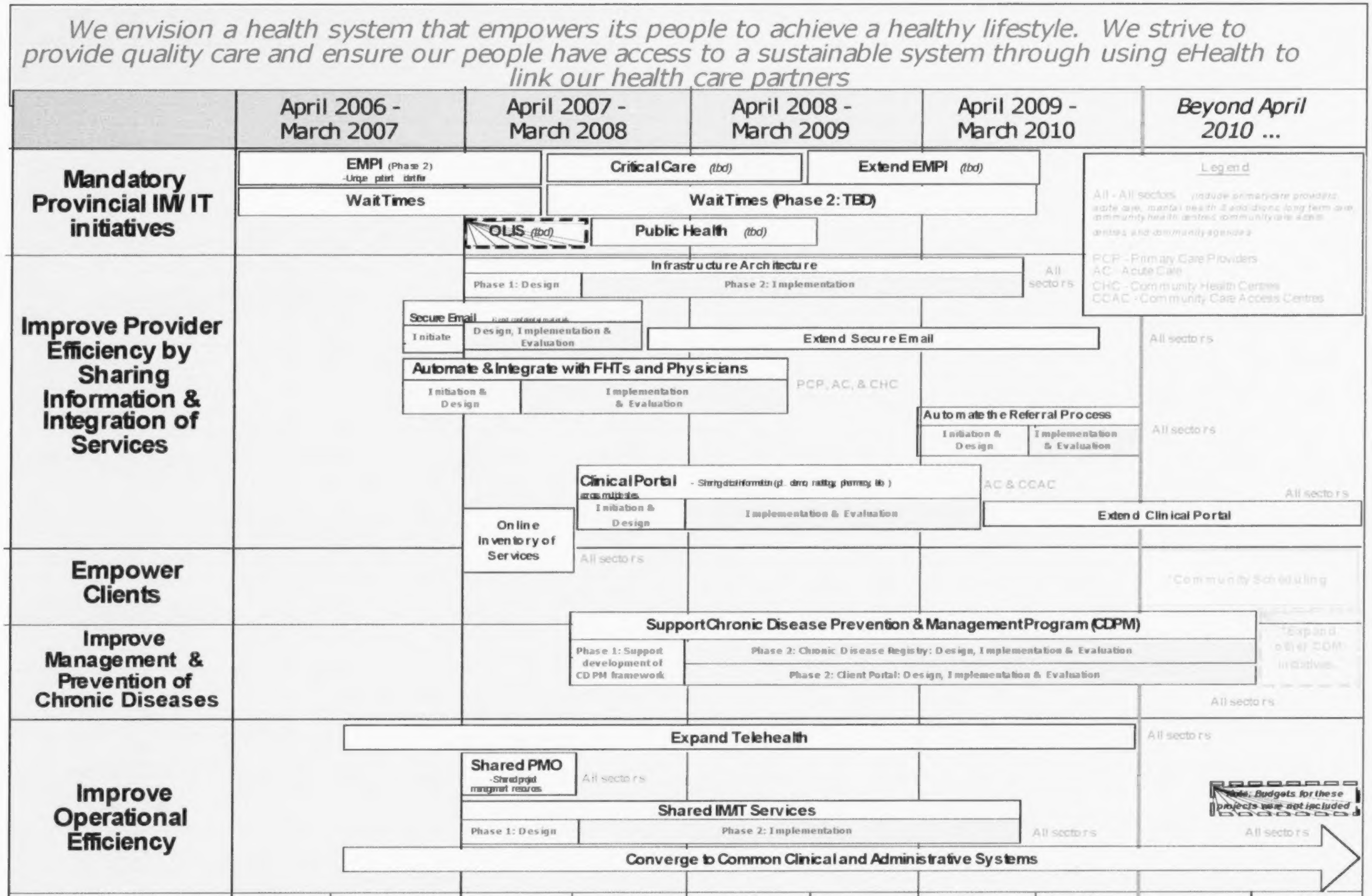
	April 2006 - March 2007	April 2007 - March 2008	April 2008 - March 2009	April 2009 - March 2010	Beyond April 2010 ...
One Time Costs	$1.6 M	$13.0 M	$18.5 M	$17.1 M	$9.8 M
Annual Operating Costs	$0	$1.3 M	$2.1 M	$3.1 M	$4.8 M
Total Costs	$1.6 M	$14.3 M	$20.6 M	$20.2 M	$14.6 M

An additional 20% has been added to all project one time costs for contracting human resources due to resource constraints. 10% has been added to all project ongoing costs to address ongoing human resource constraints. 6% of total one time costs has been added to ongoing costs for evergreening and providing support for smaller agencies. In addition, another 15% contingency has been applied to all costs. **Costs for initiatives that are beyond April 2010 have not been budgeted.**

Here are the one-time and annual ongoing cost for each initiative over the next 5 years

Initiative	Duration (Months)	One-Time Cost	Annual Ongoing Cost
Support MOHLTC Projects	42	$10,500,000	
Infrastructure Architecture	30	$1,720,000	
Secure Email	36	$2,130,000	$180,000
Automate and Integrate with Physician Offices	21	$1,420,000	$680,000
Automate Referral Information Management Process	12	$1,100,000	$140,000
Clinical Portal	45	$9,900,000	$1,380,000
Online Inventory of Services	6	$180,000	$35,000
Supporting Chronic Disease Prevention & Management	36	$7,000,000	$1,160,000
Shared PMO	6	$490,000	$1,750,000
Shared IM/IT Services	20	$630,000	$210,000
Expand Ontario Telehealth Network	42	$665,000	$600,000
Converge to Common Admin and Clinical Systems	54	$7,520,000	
20% for Contracting Resources (10% ongoing)		$8,760,000	$614,000
5% (of 1 time costs) for Evergreening			$3,100,000
15% Contingency Across all initiatives		$7,900,000	$1,500,000
Total		**$61,000,000**	**$11,300,000**

This roadmap depicts the resource implications of the LHIN's 5 year strategy



We envision a health system that empowers its people to achieve a healthy lifestyle. We strive to provide quality care and ensure our people have access to a sustainable system through using eHealth to link our health care partners

April 2006 - March 2007

April 2007 - March 2008

April 2008 - March 2009

April 2009 - March 2010

Beyond April 2010 ...

Mandatory Provincial IM/IT initiatives

EMPI (Phase 2)
-Unique patient identifier

Critical Care *(tbd)*

Extend EMPI *(tbd)*

Wait Times

Wait Times (Phase 2: TBD)

OLIS *(tbd)*

Public Health *(tbd)*

Improve Provider Efficiency by Sharing Information & Integration of Services

Infrastructure Architecture
Phase 1: Design
Phase 2: Implementation
All sectors

Secure Email [illegible]
Initiate
Design, Implementation & Evaluation

Extend Secure Email
All sectors

Automate & Integrate with FHTs and Physicians
Initiation & Design
Implementation & Evaluation
PCP, AC, & CHC

Automate the Referral Process
Initiation & Design
Implementation & Evaluation
All sectors

Clinical Portal - Sharing clinical information (pt. demo, radiology, pharmacy, lab) across multiple sites
Initiation & Design
Implementation & Evaluation
AC & CCAC

Extend Clinical Portal
All sectors

Online Inventory of Services
All sectors

Empower Clients

*Community Scheduling

Improve Management & Prevention of Chronic Diseases

Support Chronic Disease Prevention & Management Program (CDPM)
Phase 1: Support development of CDPM framework
Phase 2: Chronic Disease Registry: Design, Implementation & Evaluation
Phase 2: Client Portal: Design, Implementation & Evaluation

*Expand other CDM initiatives
All sectors

Improve Operational Efficiency

Expand Telehealth
All sectors

Shared PMO
-Shared project management resources
All sectors

Shared IM/IT Services
Phase 1: Design
Phase 2: Implementation
All sectors

Note: Budgets for these projects were not included

Converge to Common Clinical and Administrative Systems
All sectors

Legend

All - All sectors include primary care providers, acute care, mental health & addictions, long term care, community health centres, community care access centres and community agencies

PCP - Primary Care Providers
AC - Acute Care
CHC - Community Health Centres
CCAC - Community Care Access Centres

	FTEs	HeadCount	FTEs	HeadCount	FTEs	HeadCount	FTEs	HeadCount	FTEs	HeadCount
One Time Peak Resources	13.5	16.0	18.4	23	19.3	41	26.3	43	8.5	24
Ongoing Resources	2.0	3	7.0	10	9.1	13	16.1	20	22.1	24
Total Peak Resources	**15.5**	**19.0**	**25.4**	**33**	**28.3**	**54**	**42.4**	**63**	**30.6**	**48**

In order to achieve the LHIN e-Health vision, sustained and committed investments are required

- The total operating budget of Erie St. Clair LHIN organizations is $792 M per year *(2005/06)*
- On average, organizations within this LHIN are spending 1.63%* of their revenue on IM/IT
  - Hospitals spend 2.74%* on average
  - Others spend 1.26%* on average
- The cost of executing this plan over the next 3 years, April 2007-March 2010, is $55.1 M. This amount is equivalent to approximately 2.3% of Erie St. Clair LHIN's total operating expenditure over each of the next 3 years. This will be funded through a combination of external and internal funding
- Recognizing the amount of change and aggressive timelines of the strategy, the estimated budget spending includes a portion of costs to build capacity to deliver and ensure there is funding for change management to address provider adoption and the ability for organizations to absorb change
- IT spending in the Canadian healthcare system has been disproportionately low for years. IT investment needs to be 5-7% of total operating funding to address the level of past under-funding and to improve the quality, efficiency, and cost-effectiveness of health care delivery [1]
- Financial services, by comparison, devotes between 9% and 13% of their revenues to IT expenditures [1]

Notes:

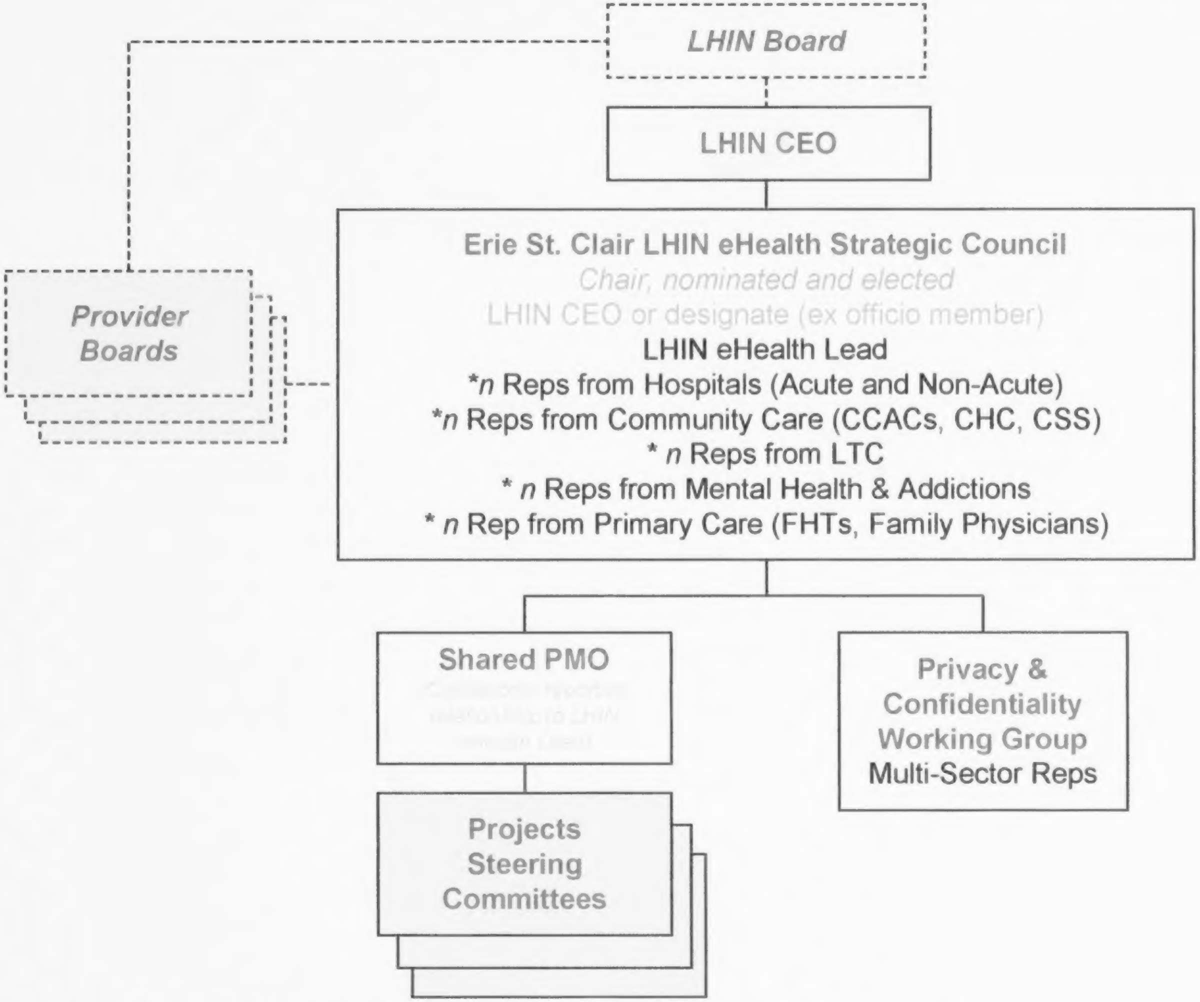
**: IM/IT spending was provided by a limited number of participants and therefore the numbers are not statistically significant*

1: Canada Health Infoway Inc: Infoway Pan-Canadian EHR Survey: Phase 1: Results and Analysis

An MOU was developed to govern the execution of this plan. It built on an existing MOU encompassing hospitals and CCACs

	First MOU	Second MOU
Intent	Promote cooperation, coordination, optimization of efficiencies and convergence of systems	Provide a framework for the planning and execution of the rolling LHIN eHealth 5 year strategic plan. Define expectations and enable consistent messaging
Scope	Hospitals and CCACs	All LHIN providers
Mandate	Establish process for making planning and operational IS/IM/IT decisions	Planning and execution of the rolling LHIN eHealth 5 year strategic plan
Duration	Not defined; developed early spring 2006	Not defined; to be reviewed annually. Developed September 2006

A key component of the MOU is an eHealth Strategic Council. This council may establish working groups to help in executing its mandate



LHIN Board

LHIN CEO

Provider Boards

Erie St. Clair LHIN eHealth Strategic Council
Chair, nominated and elected
LHIN CEO or designate (ex officio member)
LHIN eHealth Lead
**n* Reps from Hospitals (Acute and Non-Acute)
**n* Reps from Community Care (CCACs, CHC, CSS)
* *n* Reps from LTC
* *n* Reps from Mental Health & Addictions
* *n* Rep from Primary Care (FHTs, Family Physicians)

Shared PMO
[illegible] reports
[illegible] to LHIN
eHealth Lead

Privacy & Confidentiality Working Group
Multi-Sector Reps

Projects Steering Committees

** Number of reps to be determined*

Governance and Leadership is one of four factors critical to the successful delivery of the LHIN eHealth Strategic Plan

- **Governance and Leadership**
  - Successful eHealth strategy implementation is dependent upon a clearly articulated governance structure that clarifies decision making and provides credible leadership
  - Risk Mitigation Strategy:
    - Clear definition of roles and responsibilities for the following are important to ensuring integration of eHealth activities
      - LHIN CEO
      - LHIN eHealth Lead
      - eHealth Strategic Council
    - Communicate and finalize the Memorandum of Understanding
  - Establish a feedback mechanism to evaluate the success of the risk mitigation strategy

Sustainable Funding and Necessary Resources is one of four factors critical to the successful delivery of the LHIN eHealth Strategic Plan

- **Sustainable Funding and Necessary Resources**
  - Each project will require the allocation of sustained and committed funding and resources that will enable a successful delivery within the agreed upon schedule and budget
  - Risk Mitigation Strategy:
    - Confirm funding allocation model and incremental investment required on a project by project basis
    - Establish funding strategy (internal and external) for sustainable multi-year funding and/or resources
  - Establish a feedback mechanism to evaluate the success of the risk mitigation strategy

A Shared Project Management Office (PMO) is one of four factors critical to the successful delivery of the LHIN eHealth Strategic Plan

- **Shared Project Management Office (PMO)**
  - The shared PMO provides a central coordinating function and ensure the use of consistent project management methodology. The PMO will monitor shared projects to ensure that each initiative is completed successfully within budget, schedule and have met the desired outcomes
  - Risk Mitigation Strategy:
    - Establish a shared project management office (PMO) structure and staffing
    - Define formal consistent PM methodology for each project. Tools may include:
      - Project Charter
      - Status Reports
    - An MoU is established for each project
  - Establish a feedback mechanism to evaluate the success of the risk mitigation strategy

Effective Change Management and Communication is one of four factors critical to the successful delivery of the LHIN eHealth Strategic Plan

- **Effective Change Management and Communication**
  - Change management consists of stakeholder engagement, communication, training and education and process re-design. Those who will use the systems being implemented must be able to adopt them into their workflows and derive benefit from them
  - Risk Mitigation Strategy:
    - A change management and communication strategy is a resourced and funded component of each initiative
    - Resources must be assigned to enable workflow analysis and redesign
    - Resources must be provided to support initial and ongoing user education and training
    - Multiple communication channels and vehicles are required to encourage and enable the sharing of eHealth successes, best practices and knowledge within and between healthcare providers across jurisdictions
  - Establish a feedback mechanism to evaluate the success of the risk mitigation strategy

After approval of this Strategic Plan by the LHIN board, the following Action Plan should be executed

	Fiscal Year 06/07	Beyond April 2007
Establish a Communication Framework	• Provide update to all eHealth strategy participants • Brief LHIN IHSP on the eHealth strategic plan • Develop and execute a communication strategy to LHIN-wide leadership • Develop a plan for communicating and marketing the strategy within stakeholder organizations	
Implement the Governance Structure	• Finalize and approve the MOU • Finalize the LHIN eHealth Strategic Council membership • Hold first meeting of the new eHealth Strategic Council within 60 days • Determine process for refreshing the MOU	
Execute the Funding Strategy	• Develop and implement strategy for securing Ministry of Health and Long Term Care funding • Develop and execute a strategy for securing external funds • Participate in Provincial eHealth Strategy	•Participate in Provincial eHealth Strategy
Tactical Planning	• Develop a year one action plan using the remaining funds provided by the Ministry • Develop a Benefits Realization Framework for evaluating the progress and success of the strategic initiatives • Develop a process for refreshing the strategy	• Develop the shared Project Management Office • Confirm the list of shared initiatives and participants that will move forward • Clarify financial commitment on a project by project basis • Identify and secure project staff (both internal and external to the LHIN) • Develop action plan for subsequent years

Questions?

Requested action items from CEO/EDs:

- **Endorse the 5-Year Strategic Roadmap**
  - Inclusive of LHIN priorities and Provincial eHealth initiatives
- **Endorse in principle the draft Memorandum of Understanding**
- **Endorse the recommendation to retain the existing eHealth Advisory Group for the purpose of overseeing the transition from planning to execution**
- **Endorse the establishment of the LHIN eHealth Strategic Council**
- **Endorse the proposed Action Plan**

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Part II

Erie St Clair Wait Times

Provincial Wait Time Strategy – Background and Planning

> *Reducing wait times for key health services is one of the McGuinty government's top priorities and an important part of its strategy to transform the province's health system. Wait times are a symptom of a broader problem: the lack of consistent management on how patients get access to care.*
>
> *Ministry of Health and Long-Term Care Backgrounder*

In 2005 the Ministry of Health and Long Term Care introduced a wait time strategy as part of its health transformation agenda. The strategy called for reducing wait times in five priority areas:

1. Cancer surgery
2. Cardiac surgery
3. Hip and knee joint replacements
4. Cataract surgery
5. Magnetic Resonance Imaging (MRI) and Cat Scan (CT) scans

Three strategic initiatives were developed to reduce wait times in each of the priority areas. The initiatives are summarized as:

1. Capacity building through additional surgical cases
2. System and process redesign to reduce bottlenecks
3. Wait time measurement and reporting

Key initial steps were taken to implement the strategy initiatives:

- The ministry provided additional funding to hospitals, physicians and the CCAC for increased volumes in the priority areas
- The ministry identified wait time targets for the five priority areas. (See chart on page two)
- All hospitals were challenged to work toward meeting Ontario's new wait time targets

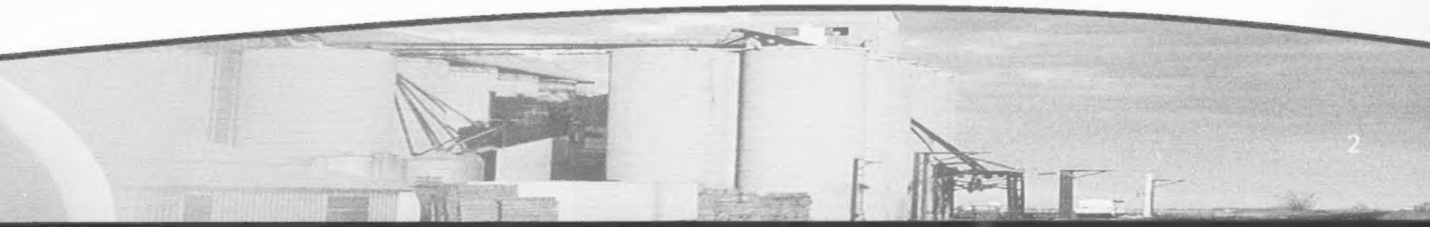


Table 1, Ontario's Wait Time Strategy: Highlights of Conditions of Funding summarizes the overall targets for this new strategy.

- Hospital will work toward meeting Ontario's Wait Time Targets, as listed below

Priority Level	Cataract	Hip & Knee Replacements	MRI Scans	Cancer Surgery	Cardiac Bypass Surgery
I	Immediate	Immediate	Immediate	Immediate	Immediate
II	6 weeks	6 weeks	48 hours	2 weeks	2 weeks
III	12 weeks	12 weeks	2-10 days	4 weeks	6 weeks
IV	26 weeks	26 weeks	4 weeks	12 weeks	26 weeks

- In 2006 the ministry began publishing public information and introduced a public web site describing wait times in Ontario: www.health.gov.on.ca. The web site tracks both the waiting times for each of the procedures as well as the current status compared to pre-identified acceptable waiting periods

- Keeping the public informed of the implementation of its wait time strategy was a key foundation of the government's wait time strategy. The public information includes measuring and reporting the results of its wait time investments. This transparency was part of an accountability process reflecting stewardship of provincial resources

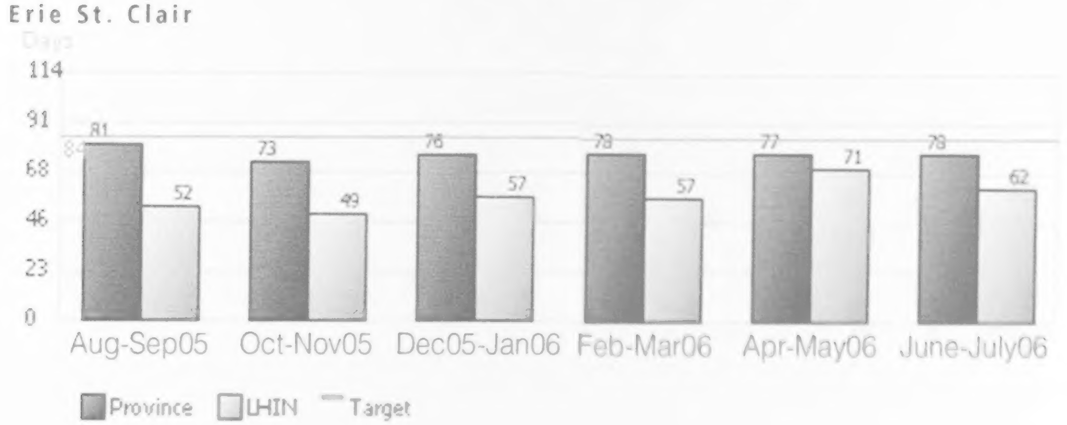
Erie St. Clair's Wait Times

As part of the provincial strategy the ministry provided the Erie St. Clair LHIN hospitals with funding to perform additional procedures for cancer surgery, cardiac angiography, cataract surgery, hip and knee joint replacements and MRI/CT scans.

The Erie St. Clair LHIN wait time results are summarized in the following sections and are accompanied by bar graphs which trend the results for 12 months ending July 2006. The results show that Erie St. Clair is within the provincial wait time targets for cancer surgery, cataract surgery, and cardiac angiography. Erie St. Clair is over the wait time targets for hip and knee replacements and MRI and CT diagnostic scans.

A. Erie St. Clair Cancer Surgery

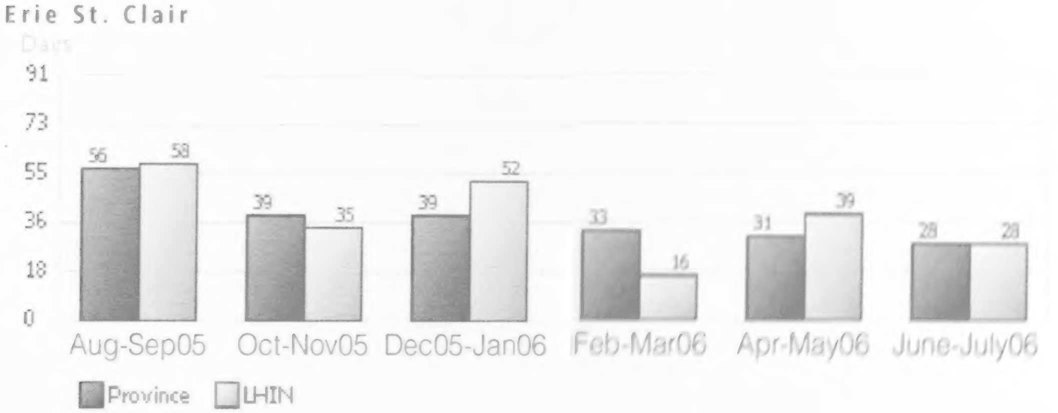
ESC has remained within the provincial target for cancer surgery over the past year



Cancer Summary The above is a compilation of all surgical cancer procedures, including but not limited to breast cancer, prostate cancer, lung cancer and colon cancer. The province wide wait time target (Priority 4) for Cancer Surgery is 84 days.

B. Erie St. Clair Cardiac Procedures

Erie St. Clair Cardiac Angiography
No provincial target is identified for this category. At the end of July 2006 Erie St. Clair had the same wait time as the province: 28 days.



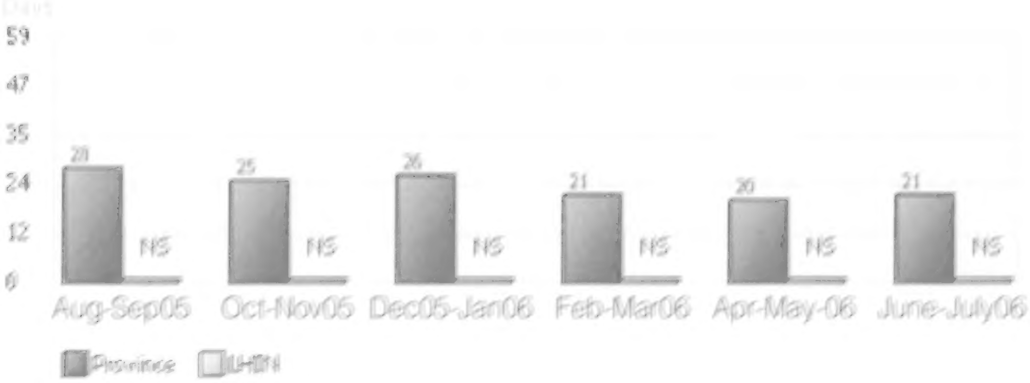
Angiography also known as cardiac catheterization an X ray is done following an injection of contrast dye in order to determine the degree of heart disease and the extent of coronary artery narrowing and blockage.

Erie St. Clair Cardiac Angioplasty

None of the hospitals within the Erie St. Clair LHIN currently perform this procedure, so we have no statistics specific to our LHIN.

The chart shows that Ontario has reduced its wait time from 28 days to 21 days over the 12 month period. The statistics for ESC were not available.

Erie St. Clair

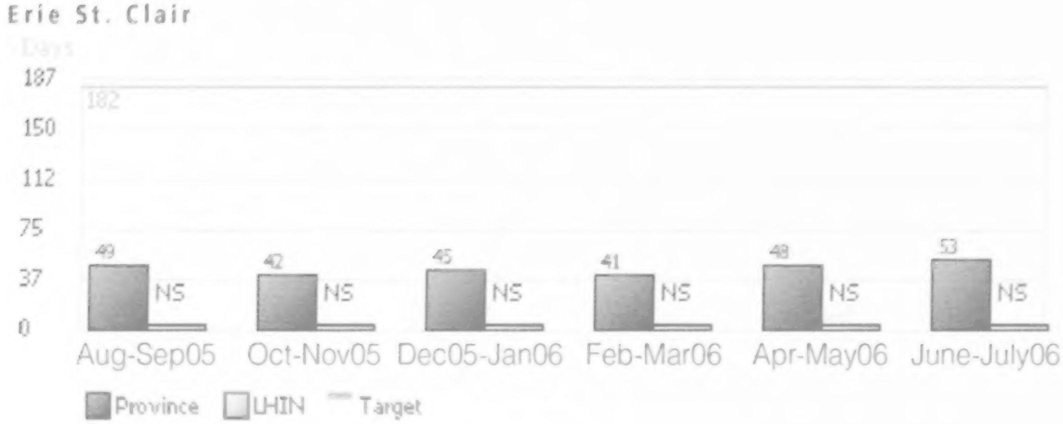


Angioplasty also known as PCI (percutaneous coronary intervention) a catheter with a small balloon tip is inserted into a narrow or blocked artery to widen it and restore blood flow, after which a small metal mesh tube, called a stent, is typically inserted and left in the artery.

Erie St. Clair Cardiac Bypass Surgery

None of the hospitals within the Erie St. Clair LHIN perform this procedure, so we have no statistics specific to our LHIN.

The provincial waiting period for bypass surgery has increased from 49 days to 53 days.

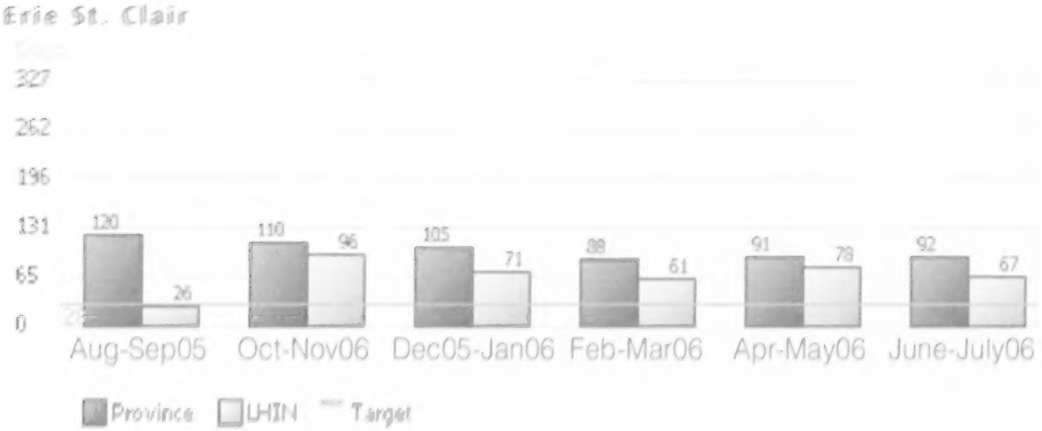


Bypass Surgery - an artery or vein is typically taken from the leg and used to bypass blockages in the heart. The wait time target (Priority 4) for Bypass Surgery is 182 days.

C. Erie St. Clair Magnetic Resonance Imaging (MRI) and Computerized Tomography (CT) Scans

Erie St. Clair Magnetic Resonance Imaging (MRI)

By the end of July 2006 Erie St. Clair, at 67 days, remained above the provincial target 28 day waiting time for MRI scans.



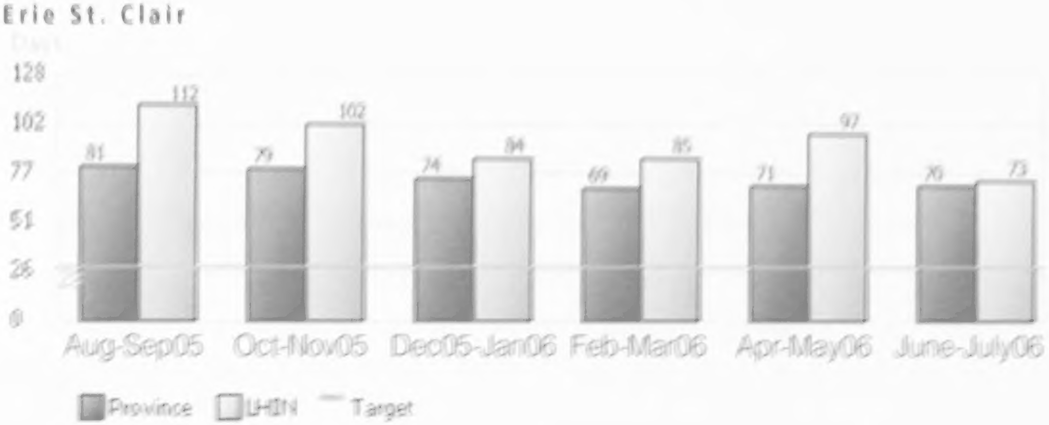
Magnetic Resonance Imaging (MRI) high quality images of areas inside the body are generated by the use a strong magnetic field and radio waves. MRI is especially useful in imaging the brain, spine, the soft tissue of joints, and the inside of bones, abdomen and pelvis and can discover cancer and other diseases. The wait time target (Priority 4) for MRI (Magnetic Resonance Imaging) is 28 days.

Note

- On September 12, 2006 the government announced funding to cover an additional 624 MRI. Erie St. Clair
- A new MRI came on line in during the summer of 2006 at the Windsor Regional Cancer Centre which will increase capacity for our LHIN

Erie St. Clair Computed Tomography (CT)

By the end of July 2006 Erie St. Clair is at 73 days, Erie St. Clair remained above the provincial target of 28 days waiting time for CT exams



Computerized Tomography (CT) uses a series of X-rays to create image "slices" (usually about one slice per millimetre) of a patient's body. When the images are stacked together by a computer, they can produce a 3-D image useful to diagnosing illness or planning radiation treatment. The wait time target (Priority 4) for CT (Computerized Tomography) is 28 days.

Note

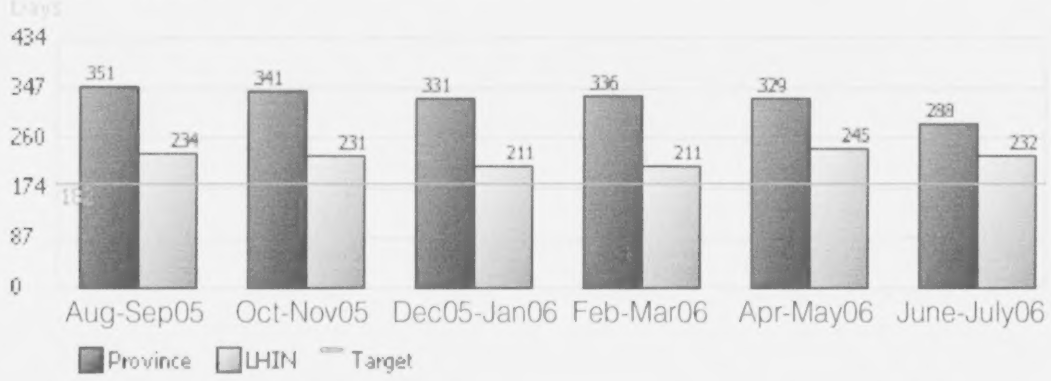
On September 12, 2006 the government announced funding to cover an additional 6,121 CT exams for Erie St. Clair.

D. Erie St. Clair Hip and Knee Joint Replacement Surgery

Erie St. Clair Hip Joint Replacement Surgery

For the past year Erie St. Clair has remained outside the target for total hip replacement wait times.

Erie St. Clair

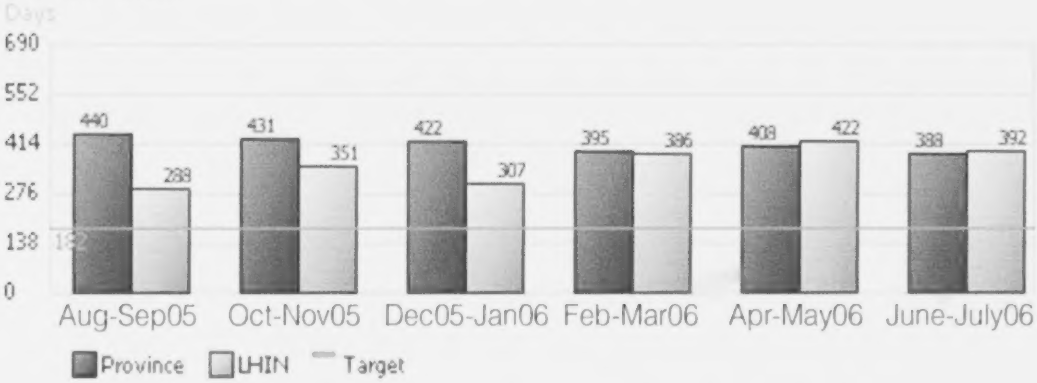


Total Hip Replacement Described as the replacement of both sides of the hip joint with a plastic socket and a metal ball and stem. The wait time target (Priority 4) for Total Hip Replacement is 182 days.

Erie St. Clair Total Knee Joint Replacement Surgery

For the past year ESC has remained outside the target for total knee replacement wait times.

Erie St. Clair

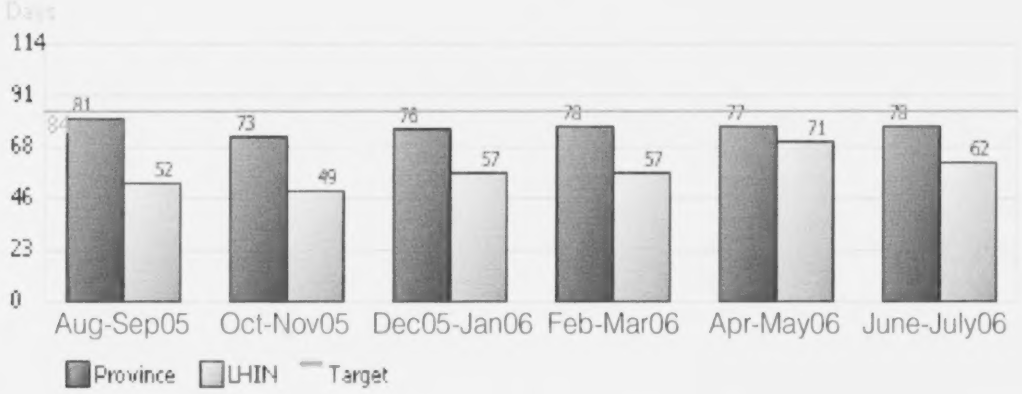


Total Knee Replacement replacement of the knee joint with three or four artificial parts. The wait time target (Priority 4) for Total Hip Replacement is 182 days.

E. Erie St. Clair Cataract Surgery

ESC has consistently remained within the target wait times for cataract surgery for the past twelve months.

Erie St. Clair



Cataract Surgery Described as the clouded lens of a patient's eye surgically removed and replaced with a human made lens. The wait time target (Priority 4) for Cataract Surgery is 182 days.

Readiness Activities

The Erie St. Clair LHIN has held two meetings to educate and inform the providers about wait times. The first meeting's focus was a presentation by Dr. Alan Hudson, Lead of Ontario's Wait Time Strategy. Providers from across the LHIN were invited and approximately 75 attended.. The second meeting was held at the LHIN office and the main presenter was Hugh McLeod, Assistant Deputy Minister for the MOH/LTC. There was representation from all the hospitals within the LHIN and the medical staff leadership. The focus of this meeting was to update the wait times status for our LHIN and to share best practices from across the province. Following these two meetings we have moved forward and created a Wait Time Steering Committee for the Erie ST. Clair LHIN.

The Wait Time Steering Committee will develop strategies and plans to work towards meeting or exceeding the goals for the wait time strategy in Ontario. The steering committee has representation from all of the hospitals within the LHIN, the CCAC, Medical Staff leadership and the Rehabilitation Network. The committee is currently working on the following initiatives:

- **Medical Staff Involvement and Input** Meeting with the Chiefs of Staff, Chiefs of Surgery, Anesthesiologists, Ophthalmologists and Orthopedists to discuss possible Wait Time strategy opportunities and to share best practices from across the province
- **Best Practices** The committee is looking at projects and processes that have already been funded by the Wait Time Team and are perceived as best practices, with possible application for our LHIN. These include the following:
  - Standardized care plans for hip and knee surgeries that include the pre operative, post operative and community care for the patients
  - Standardized education for staff and patients about their joint replacement surgery
  - Increased access to rehabilitation services both before and after surgery to decrease time in the hospital
  - Differential diagnosis and triage for mental health patients in the emergency department to decrease wait times
  - Continue to scan the province for other best practices that might assist our LHIN
- **Coaching Teams** The committee will also work with the Wait Time Team from the MOH/LTC by:
  - utilizing the coaching teams created for improving surgical process efficiencies in the operating rooms and

- installing the software from McKesson and Associates which will allow for better tracking of information about the surgical processes and the development of indicators to establish benchmarks and best practices

These initiatives will be ongoing over the next three years. The steering committee will develop task forces to work on specific project initiatives and report back to the steering committee. The work of the steering committee will be reported to the LHIN Board of Directors on a bi-annual basis. This committee will work closely with the Health Advisory Committee.

Erie St.Clair LHIN Challenges & Benefits

The challenges to achieving better outcomes and increased capacity in Erie St.Clair are related to:

- Health human resource limitations that include orthopedic surgeons, anaesthetists and surgical nursing staff
- Bed availability due to increased ALC days blocking the beds
- The need for process changes for the perioperative experience in hospitals
- The need for better communication and planning post operatively between the hospital staff and community care staff and additional community resources

CURRENT INTEGRATION ACTIVITIES AND PARTNERSHIPS

CURRENT INTEGRATION ACTIVITES AND PARTNERSHIPS

APPENDIX I

Introduction

Since its inception, the Erie St. Clair Local Health Integration Network (LHIN) has participated in meetings, forums, and service provider board sessions. A variety of methods have been implemented to engage citizens across the LHIN, in order to create awareness, introduce the agency's mandate and encourage a well rounded dialogue about present and future health care services. A summary of key integration/community engagement activities is set out below.

Planning Process

An Integrated Health Services Plan (IHSP) Steering Committee was developed to oversee the planning process and to give insights into, and a context for local issues. The steering committee was supported by three geographic teams, one each from Essex County, Lambton County and the Municipality of Chatham-Kent, which provided input and advice on local priorities.

Members of the steering committee/geographic teams were selected with the need to ensure a balanced and broad perspective in mind. In particular, attempts were made to provide the following perspectives: urban and rural, multiple segments of the health care sector, provider/consumer, Francophone and Aboriginal stakeholders.

The steering committee and geographic teams included local health care providers, physicians, community members and LHIN board members. Their role included assisting LHIN staff in the collection and dissemination of information, engaging members of the community in dialogue, further enhancing the LHIN's staff knowledge of the health care system, providing guidance on inter-LHIN issues and ultimately helping shape the IHSP.

LHIN staff developed the following operational guidelines for the committee and teams.

Decision Support Team

An existing group of data management leaders within the Erie St. Clair LHIN originally brought together for a data quality initiative spearheaded by the Ministry of Health and Long-Term Care agreed to serve as the

Erie St. Clair LHIN Decision Support Team. The team included representatives from all area hospitals and CCACs. Representatives agreed to serve as members of the Erie St. Clair Decision Support Team to assist with collecting data and providing input on data quality issues related to the development of the Integrated Health Services Plan. Our Decision Support Team assisted the Erie St. Clair LHIN staff with identifying emerging trends and major issues impacting on local health care delivery in their organizations from a data management perspective. In the future, the Erie St. Clair LHIN will broaden the scope of representation on our Decision Support Team to also include the valuable input of data collection specialists from community agencies and public health units within our area.

Steering Committee

Prescribed activities to shape the work of the committee:

- Review and validate data findings generated through the environmental scan
- Provide additional context on processes, strengths, weaknesses, gaps, and unresolved issues
- Verify the IHSP interpretation and understanding of the data and processes
- Provide focus on the key emerging integration priorities developed through public consultation
- Act as a credible conduit, or link between the LHIN and area residents
- Ensure that health care providers and consumers have input into the planning process
- Develop criteria for determining local health care priorities
- Advise LHIN of integration priorities
- Direct the geographic teams to provide focused feedback on local integration issues

Skills and experience desired for the consultative roles of selected individuals:

- Knowledge of the health care system interactions among health service providers
- Knowledge of the health care system interactions among health service functions
- Experience in understanding the complexity of health care service provision
- Knowledge of community based services
- Knowledge of Ministry of Health and Long Term Care services
- Knowledge of community and health care issues
- Ability to identify and interact with key stakeholders empowered to address health care system issues

Geographic Teams

Prescribed activities to shape the work of the committee:

- From a county-wide perspective, review and validate data findings generated through the environmental scan
- Provide additional county-wide context on processes, strengths, weaknesses, gaps, and unresolved issues
- Verify staff IHSP interpretations and understandings of county wide data and processes
- Provide focus on the key, emerging integration priorities developed through public consultation

- Act as an adjunct to the steering committee
- Provide local health care providers and consumers with an opportunity for input into the planning process
- Explore opportunities for improved access, quality, system approaches, and improved system sustainability

Skills and experience desired for the consultative roles of selected individuals:

- Knowledge of the health care system interactions among health services providers
- Knowledge of the health care system interactions among health service functions
- Experience in understanding the complexity of health care service provision
- Knowledge of community based services
- Knowledge of Ministry of Health and Long-Term Care services
- Experience as a user of health care services
- Ability to identify and interact with key stakeholders empowered to address health care issues
- Possess a rural/urban perspective

To guide the planning process, the following key participation principles were formulated for the steering committee and geographic teams:

- Act as a community member rather than as an advocate of specific service changes
- Assure the participating population that the LHIN decision-makers are listening to the views of providers and stakeholders and that the LHIN values feedback
- Reinforce that decisions are being developed and made collectively with the community
- Reinforce that equity and respect for diversity is being upheld as a key principle
- Reinforce that the core issues identified by the community will be addressed
- Confirm the LHIN commitment that the right people are around the table to discuss important issues and recommend solutions to problems
- Expect bi-weekly meetings

Terms of reference for the committee were developed in order to guide the process.
The terms of reference for the steering committee and geographic teams are summarized below in exhibits A and B, respectively.

An orientation session was held in April for all steering committee and geographic team members. During the session, members received briefings from the LHIN CEO and senior directors on the roles and function of the committee/teams, the local Health System Monitoring Report and the IHSP and its components. The steering committee and geographic teams met regularly during the period from April to September 2006, and provided invaluable advice and guidance to the LHIN planning staff.

The following key principles were incorporated into the planning process:

- Patient focus
- Sustainable outcomes
- Build on current, successful integration activities
- Engage the community, involving providers and consumers of health care services
- Use verifiable and reliable information and data
- Recognize uniqueness of communities within the context of overarching LHIN objectives

Community Engagement Forums (Round Tables)

In the fall of 2004, the Ministry of Health and Long Term Care asked a committee of local health and community leaders to report on local health care "priority issues." The Erie St. Clair LHIN has used the resulting priority issues in its community engagement process.

The LHIN held community engagement forums (round table meetings) with the following objectives:

- Engaging the public in their locale
- Informing and educating the community about the IHSP process
- Providing an overview of the overall population health of Erie St Clair residents
- Reviewing the 2004 priority issues report in order to determine if they are still valid
- Discussing the community's issues and priorities

These open, round table consultation sessions were also attended by health service providers, news media, and, in some cases, family health teams and community health centre leaders. LHIN staff members were available to answer questions on a one to one basis. The sessions, held throughout the LHIN, were widely advertised in local media. To summarize:

- Four sessions were held in Lambton County, with a total attendance of 139
- Four sessions were held in the Municipality of Chatham-Kent, with a total attendance of 106
- Five sessions were held in Essex County, with a total attendance of 147
- Two French language sessions, one in Windsor and one in Pain Court, were also held, with a total attendance of 54
- One session was held at the Windsor Homeless Mission, with a total attendance of 25
- One session was held at the Windsor Teen Health Centre, with a total attendance of 14

The total attendance for all of the round table community engagements was 485 participants.

Further round table sessions are planned for local aboriginal communities, the hearing impaired and other stakeholder groups.

Street Surveys

Another major component of the community engagement process was the "Feet on the Street" initiative. A questionnaire for individuals was developed, based on key themes that emerged during the round table engagement sessions. Ten university students were assigned to various locations throughout the LHIN over the summer months and used the surveys to engage citizens in an informal environment concerning health care issues. Overall, the survey technique reached over 7,400 citizens of the LHIN. The results are being analyzed to assist in the development of LHIN priorities. (See Appendix D for summary results).

Survey of Integration Activities Underway or Planned

As part of the IHSP development, the LHIN decided to, where possible, build onto integration initiatives already underway, or being planned by local health care agencies/groups. To identify such opportunities, two questionnaires were developed: Survey #1 was designed to collect details of current integration activities, including formal integration partnership agreements. Survey #2 collected information on integration activities being considered over the next 1-3 years, where a possible role for the Erie St. Clair LHIN existed.

Both surveys were distributed to over 80 health care organizations whose services fall within the mandate of the LHIN. Copies of the survey questionnaires are presented in exhibits C and D.

A total of 27 organizations responded to Survey #1. It is noteworthy that the responding organizations collectively account for approximately 90 percent of the Ministry of Health and Long-Term Care funding allocated to organizations within the LHIN. It should also be noted that responses were received from all hospitals, Community Care Access Centres, and Community Mental Health Associations in the area.

An analysis of Survey #1 responses indicated that

- The majority of integration/partnership agreements are within one sector (hospitals) and coverage is within one administrative area (county)
- Most agreements focus on programs and services
- The main strategic goals addressed by the agreements/partnerships are service coordination, as well as the integration and effective/efficient use of resources

Within each health sector the following key findings were noted:

- Hospitals have mainly developed agreements, which cover one sector, apply to programs and services, and address coordination/integration goals
- Community Care Access Centre agreements mainly address cross-sector arrangements within one administrative area. Their focus is mainly on programs/services and specific medical conditions, with key

goals focusing on coordination/integration and system sustainability

- Mental health and addictions agreements tend to be cross sector in type, and within one administrative area. The majority of the agreements focus on programs and services, with the key goal being integration and coordination
- Community Health Centre agreements tend to be within one sector and one administrative area. The majority of the agreements focus on programs/services and the main goal is co ordination and integration
- Although only a limited response was received from the long-term care (LTC) sector, agreements tended to be within one sector and across administrative functions. The focus of the agreements was programs and services. The main goals are coordination and integration, as well as the effective/efficient use of resources

Survey # 2 asked respondents to identify integration projects, or initiatives intended for the next 1 3 years. A total of 24 organizations responded to the survey. The responses were analyzed and grouped by sector, under key priority themes, as presented in the following table:

Intended Integration Initiatives and Key Priorities

Sector (from Survey # 2)	Key Priority Themes
Hospitals	Specialized geriatrics and interface between long-term and acute care sectors
Community Care Access Centres	Chronic disease management
Community Support Organizations	Information technology/electronic health records, transportation (non-ambulance) and community rehabilitation
Mental Health and Addictions	Divestment of services to the community where appropriate, primary care needs of persons with serious mental illnesses, and integration of the mental health system and addictions system
Community Health Centres	Keeping seniors at home and diabetes programs

Over 80 per cent of the respondents to Survey # 2 indicated that the LHIN could potentially play a facilitation/mediation role in future initiatives. Approximately 50 per cent indicated that the LHIN could assist in data preparation/analysis, priority setting, the development of goals/performance measures and the standardization of agreement formats.

In addition to the survey, a number of other sources were used to develop a comprehensive picture of potential integration opportunities/projects for inclusion in the IHSP. These included:

- The Priorities for Integration Report (Nov. 2004) prepared by local health care providers immediately prior to the establishment of the LHINs
- Hospital Annual Planning System Report (2005)
- Survey of physician leaders (July 2006)
- Analysis of information/data contained in the environmental scan, with particular focus on identifying emerging trends and unmet needs
- Dialogue and feedback provided to the LHIN senior staff and board of directors during meetings and presentations with key local stakeholders

Following a review of the above-noted information, several projects/opportunities were identified where the LHIN could provide leadership. These included: access to primary care, shortages of health professionals, transportation, improving wait times, system navigation and the development of an overarching Erie St. Clair chronic disease management strategy/planning framework.

Criteria and Process Used to Determine Integration Priorities

The information and data described above was analyzed by the staff, with key themes/potential opportunities identified. Following further analysis and input from the LHIN board, the steering committee and geographic teams, eight strategic directions (SIDs) were developed. These are:

- Chronic disease management
- Systems navigation
- Health promotion and illness prevention
- Reduce dependence on hospital-based services
- Access issues
- Back office, including the electronic health record
- Health human resources (recruitment and retention)
- Supporting people at home

The SIDs are described in more detail in Appendix G.

Concurrently, a strategic priorities framework, shown in Figure 1 following, was developed and endorsed by the steering committee.

Erie St. Clair Strategic Priorities Framework

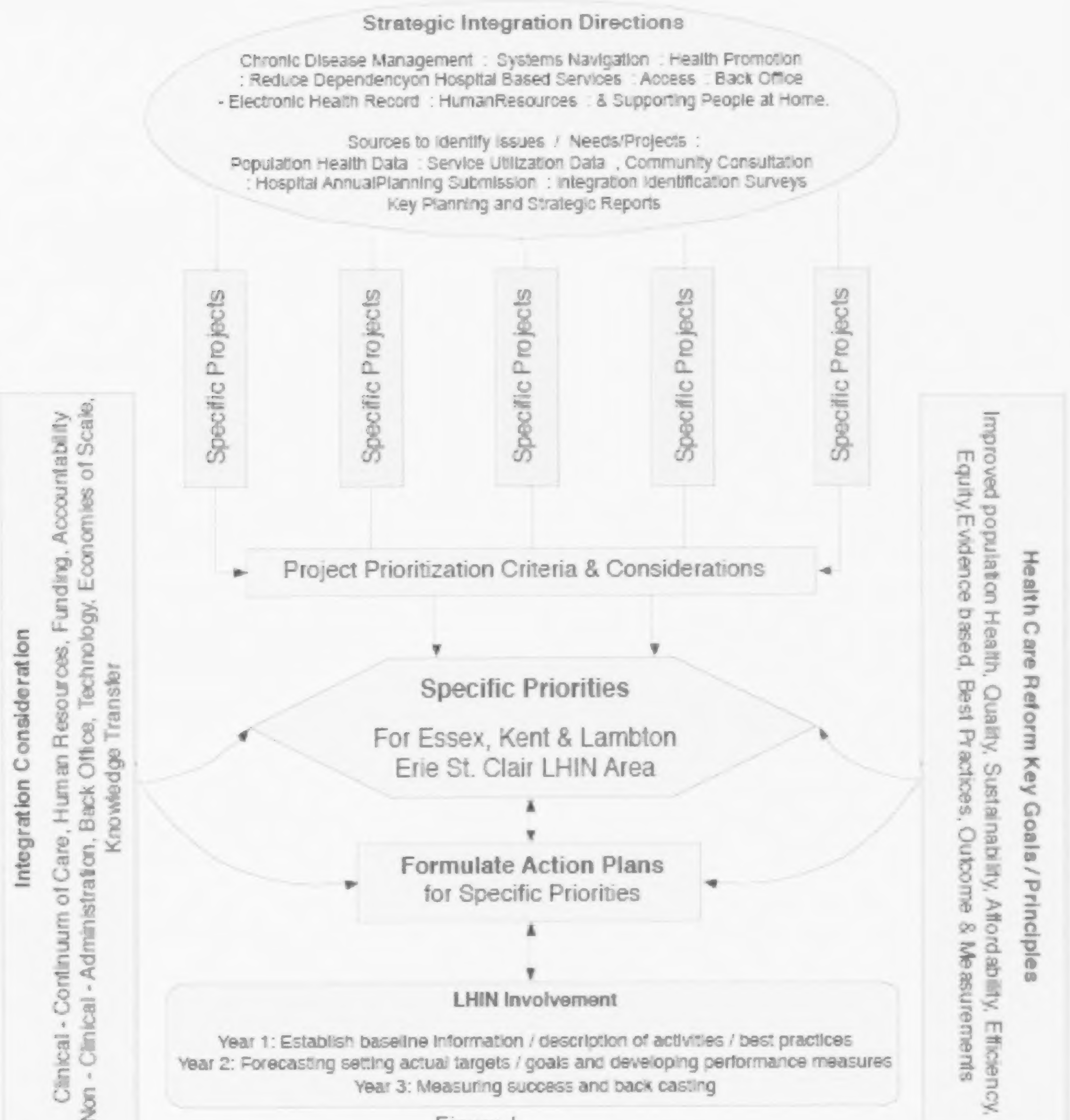

Strategic Integration Directions
Chronic Disease Management : Systems Navigation : Health Promotion
: Reduce Dependencyon Hospital Based Services : Access : Back Office
- Electronic Health Record : HumanResources : & Supporting People at Home.
Sources to identify issues / Needs/Projects :
Population Health Data : Service Utilization Data , Community Consultation
: Hospital AnnualPlanning Submission : Integration Identification Surveys
Key Planning and Strategic Reports
Specific Projects
Specific Projects
Specific Projects
Specific Projects
Specific Projects
Integration Consideration
Clinical - Continuum of Care, Human Resources, Funding, Accountability
Non - Clinical - Administration, Back Office, Technology, Economies of Scale, Knowledge Transfer
Project Prioritization Criteria & Considerations
Specific Priorities
For Essex, Kent & Lambton
Erie St. Clair LHIN Area
Formulate Action Plans
for Specific Priorities
LHIN Involvement
Year 1: Establish baseline information / description of activities / best practices
Year 2: Forecasting setting actual targets / goals and developing performance measures
Year 3: Measuring success and back casting
Health Care Reform Key Goals / Principles
Improved population Health, Quality, Sustainability, Affordability, Efficiency, Equity,Evidence based, Best Practices, Outcome & Measurements

Figure I

In excess of 300 potential integration projects/initiatives were identified from the various information sources shown in Figure 1. Therefore, prior to applying the framework, an initial review of each was carried out. The objective of the review was to determine how closely the objectives of each potential projects/initiatives aligned with the LHINs definition of integration, as developed by Stephen M. Shortell (1996). The definition was adopted by the LHIN as a key objective for its integration activities:

Integration

The extent to which services are received as part of a coordinated and uninterrupted series of events, consistent with the medical needs of the client/patient.

By evaluating potential projects/opportunities against Shortell's definition, an initial short list of projects was developed. Follow up discussions were then held with key contacts/sponsors of the potential priority projects/opportunities helped determine their state of development and suitability for inclusion in the LHIN's IHSP. The review identified the following projects/initiatives for inclusion in the IHSP:

- Community Geriatric Assessment Network
- Acute inpatient psychiatry/community mental health linkage
- E chart initiatives
- Geriatric mental health partnership
- Cancer Services Integration Agreement
- Shared Services Agreement for information technology services
- Integrated supply chain management model
- Mental Health Collaboration Committee
- Psycho geriatric urgent response protocol
- FOCUS program(teen addictions)
- Tri-county community mental health agencies initiative
- Tele Education for community physicians on palliative care
- Community palliative care partnership
- Development of diabetes care models/network
- Erie St Clair Rehabilitation Network
- Regional Infection Control Network planning
- Arthritis Society initiatives related to " Prehab" and provision of services to persons awaiting knee or hip surgery
- Concurrent Disorders Network
- Cross sector shared staffing arrangements
- System navigation initiatives for selected diseases
- Dual diagnosis programs

- Chatham Kent CCAC and Association Canadienne Française French Language Service Initiative
- Shared after care model for addictions
- Divestment of mental health services (Tier II, III)
- Integration of back office services (especially for smaller agencies)
- Integration/coordination of recruitment and training of volunteers
- Integration/coordination of Continuing Education programs for health care professionals

The above potential projects/initiatives were further analyzed in the context of information/data received from the other sources previously described sources. The Figure 1 framework was used to develop an initial list of potential integration priorities/opportunities. The list was then reviewed by the steering committee and the geographic teams, and a number of changes were incorporated into a final list of priority projects. The final list was reviewed and approved by the LHIN board.

Integration Priorities

Using the prioritization criteria described in Appendix H, led to the identification of two broad categories for projects, Strategic or System Projects, and Enabling Projects. The former are those where a leadership role for the LHIN was identified. The latter list consists of projects under development by a group(s), which would benefit from LHIN assistance and facilitation. In essence, both lists represent potential opportunities for early successes.

Detailed action plans for the priority Strategic or System Projects and Enabling Projects as identified under each strategic integration direction, are shown in Appendix G.

Conclusions and Next Steps from the Planning Process

Based on the integration survey results, feedback provided from key local stakeholders, health care leaders, and the other information sources previously identified, it is evident that considerable integration activities are already occurring in the Erie St. Clair LHIN. In fact, several of the integration initiatives preceded the formation of the LHIN. Moreover, it is clear that local health service organizations are eager to constructively participate in partnership(s) with the LHIN and other agencies, to further enhance/expand their integration efforts.

Activities Accomplished by the LHIN

A main objective of the LHIN has been to form strong relationships with its communities and with health care providers. The LHIN continues to listen to the views and issues of its community. Related activities of the LHIN include:

- Establishing governance procedures and policies
- Developing sustained relationships
- Recruiting staff
- Developing and implementing business processes
- Facilitating local family health teams and community health centre proposals
- Building evidence based data sources that are reliable and valid
- Developing a wait time strategy steering committee
- Developing a framework for performance management
- Networking with other LHINs
- Working with the Ministry of Health and Long Term Care regional office for the transition of responsibilities
- Working with cancer care organizations in Windsor and London
- Participating in the Ministry of Community and Social Services' planning process for Lambton
- Aligning with the cardiac rehabilitation and heart and stroke networks
- Developing an e-health strategy group

Activities in Progress by the LHIN

With the completion of the IHSP, the LHIN will focus on:

- Continued community engagement with select populations, aboriginal groups and other segments of the population
- The development of the Health Providers Advisory Committee
- Realigning the steering committee and geographic teams to a more evolved advisory function
- Developing and enhancing function-focused networks
- Embarking on an exercise to enhance community understanding of the scope and functions of local providers accountable to the LHIN
- Developing sector reviews in order to determine strengths, weaknesses, opportunities, and threats to existing and potential processes

Next Activities

- Develop a family physician advisory group
- The LHIN board of directors will develop and implement an educational workshop for the directing boards of local health care service providers
- Meet with local physicians to determine best practices for reducing wait times
- Educate local health service providers, stakeholders, media and community members about the Erie St. Clair IHSP

Exhibit A

Steering Committee Terms of Reference

Purpose

- Bring the perspective and insights of all residents of Erie St. Clair
- Provide advice to the LHIN on opportunities to develop a more patient-centered health care system in Erie St. Clair
- Help identify the health care priorities for the Erie St. Clair LHIN for the next three years, by considering the needs of the communities and services offered, as well as opportunities to develop a seamless system across care settings, maximize program cost-effectiveness and improve program efficiency
- Provide an opportunity for greater collaboration among institutional and community-based providers, and the community as a whole, in health care planning
- Identify and bring forward to the LHIN issues of concern to the community for consideration and/or action
- Identify opportunities for integration in Erie St. Clair and other regions that border our LHIN

Function

- With input from the geographic teams and service providers, review the environmental scan information concerning population health, health system utilization and structures
- With input from the geographic teams, recommend opportunities to develop an improved health care system in Erie St. Clair to:
  - Improve access
  - Improve quality
  - Work as a system
  - Improve sustainability
- Develop criteria for determining health care priorities for the Erie St. Clair LHIN
- Based on the analyses of the environmental scan, other data, community engagement and in consideration of provincial priorities, recommend the health care priorities, objectives, strategies for action, and implementation plan for the IHSP
- Recommend an evaluation and monitoring plan for the IHSP

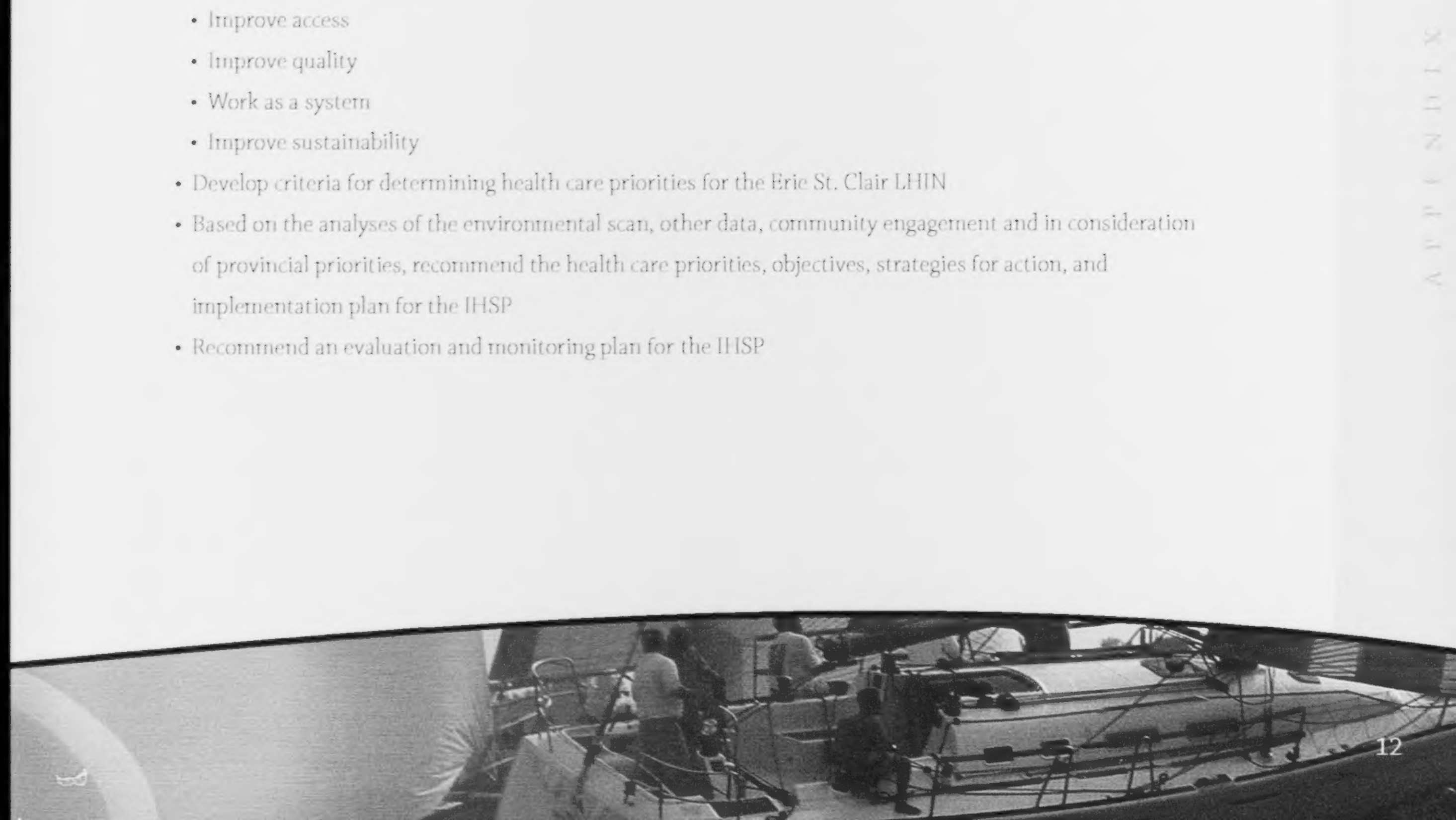


Exhibit B

Geographic Teams Terms of Reference

Purpose

- Provide information to the steering committee and the LHIN staff on the IHSP concerning opportunities to integrate programs across care settings, maximize program cost-effectiveness and improve program efficiency
- Provide an opportunity for greater collaboration among institutional and community based providers, and the community as a whole, in health care planning

Function

- Review the following environmental scan information for their geographic area and provide advice to the steering committee:
  - Population health
  - Health services utilization
  - Services available
  - Trends analysis
  - Gaps in services identify by the community (providers & citizens)
- Review the evaluation and assessment analysis for their geographic area and provide advice to the steering committee
- Explore opportunities for:
  - Improving access
  - Improving quality
  - Working as a system
  - Developing a sustainable health care system in their geographic area
- Provide advice to the steering committee on the health care priorities and integration opportunities for their geographic area
- Identify and bring forward to the steering committee issues of concern to the community for consideration and/or action
- Provide advice and assistance in developing and implementing diverse stakeholder engagement strategies to ensure that the community has opportunities to be involved throughout the process

Exhibit C

Erie St.Clair
LOCAL HEALTH INTEGRATION NETWORK
RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
d'Érié St-Clair

Service Provider Operational/Integration Agreements
Survey #1 - Current Initiatives

Please complete one survey for each current integration agreement that you are identified as the "lead" agency on and return by June 6th, 2006 to: eriestclair@lhins.on.ca. Also provide a copy of these current operating agreement(s) in electronic format (if possible) when returning this survey.

Organization: ____________________

Name/Title of Person Completing Survey: ____________________

Telephone & Email Address: ____________________

1. Name/Title of Existing Service Agreement: ____________________

____

2. Agreement came into effect on: ____________________

3. Lead Agency ____________________

4. Key Parties Involved with Service Agreement (list):

____

____

____

____

Service Provider Operational/Integration Agreements (cont'd)

Survey #1 - Current Initiatives

5. Scope of Agreement Coverage (✓ those that apply)

☐ Within one Sector (e.g. Mental Health only)
☐ Across Sector (e.g. Long Term Care, Mental Health, Hospital, etc)
☐ Within one Geographic Area (Essex County)
☐ Across Geographic Areas (combination of Lambton, Chatham-Kent, Essex)

6. Agreement Main Focus (✓ those that apply)

☐ Population Health (e.g. obesity)
☐ Disease Specific (e.g. diabetes)
☐ Programs and Services
☐ Administrative Areas

- Wait Times
- Other Areas (e.g. IT / HR) state area

____

7. Agreement Goals (✓ those that apply)

☐ Elimination of Barriers to Access

- Commitment to Service Equity and Diversity
- Better Coordination/Integration

☐ More Effective & Efficient use of Health Resources

- Sustainable Services
- Other Goals (specify):

____
____
____
____
____
____

Service Provider Operational/Integration Agreements (cont'd)

Survey #1 - Current Initiatives

8. Is this Agreement:

☐ Still Current
☐ Needs to be Updated

9. Do you think that this agreement has been successful enough to be considered as a model for agreement development and should be referenced in our Integrated Health Service Plan this year?

______ Yes ______ No

10. Other Comments:

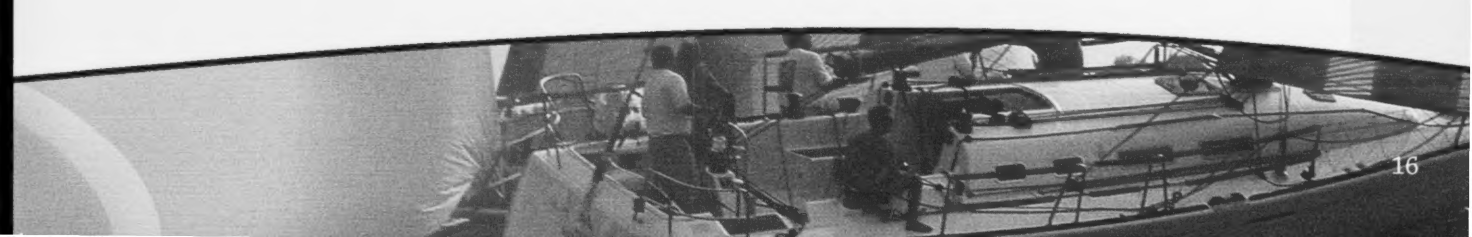


Exhibit D

Service Provider Operational/Integration Agreements
Survey #2 - Future Initiatives

Please complete this survey by indicating future priority areas where service integration agreements may need to be developed (within 1 year and 2-3 years) and return by June 6th, 2006 to: eriestclair@lhins.on.ca.

Organization: ______________________________

Name/Title of Person Completing Survey: ______________________________

Telephone & Email Address: ______________________________

- Potential priority/priorities for Service Agreement Development that your agency is contemplating leading (over the next 12 months):

____

____

____

____

____

____

____

____

Why are these a priority?

____

____

____

____

____

Service Provider Operational/Integration Agreements (cont'd)
Survey #2 - Future Initiatives

2. Potential areas for Service Agreement Development that your agency would take the lead to develop (over the next 2 - 3 years):

3. Strategically, please indicate which priority integration areas you plan to cover with the service agreements proposed above (✓ those that apply):

Service Agreement Development Priority Area(s):	**Within next 12 months (✓)**	**Within next 2 to 3 years (✓)**
Population Health (e.g. obesity)		
Disease Specific (e.g. diabetes)		
Programs and Services		
Administrative Areas		
Wait Times		
Population Health (e.g. obesity)		
Agreements specific to one sector (e.g. Mental Health only)		
Agreements that cross sectors (LTC, Hospital, Mental Health)		
Agreements within one Geographic area (e.g. Essex only)		
Agreements cross Geographic areas (Essex/Chatham-Kent/ Lambton)		

Service Provider Operational/Integration Agreements (cont'd)

Survey #2 - Future Initiatives

In your view, which one area within our health system is most in need of a formal integration service agreement and why?

4. Do you think that LHIN Planning Staff could help to further agreement development for the areas that you have identified? _____No _____Yes

If yes indicate (✓) how:

☐ Facilitation
☐ Mediation
☐ Data Preparation
☐ Priority Setting
☐ Identification of Goals & Performance Indicators
☐ Developing a Standard Agreement Format

- Other Role(s)

5. Other Comments:

Exhibit E

Team Members

Integrated Health Services Plan & Community Engagement
Geographic Team for Lambton

Category	Name	Title/Affiliation
LHIN Board Member	Mike Hurry	Director
Hospital	David Vigar	CEO, Bluewater Health
Community Care Access Centre	Norma Unsworth	Manager, CCAC
Mental Health	Al Stevenson	CEO, Canadian Mental Health Association-Lambton County
Community Agency	Agnes Soulard	ED, Lambton Elderly Outreach
Municipality	Cindy Thayer (Chair)	General Manager, County of Lambton
Physician	Dr. Kathy Pratt	Surgeon
Physician	Dr. Bill Buckton	Family Physician
Citizen (Rural)	Mary Pat Gleeson	Charlotte's Task Force
Citizen (Urban)	Cathy Orr	
Aboriginal Representative	Dianne George	Kettle and Stony Point
Ministry of Health & Long Term Care (Regional Office) – ex officio	Mary Kay Croft Anthony Sirizzotti	Program Manager, Long Term Care Hospital Consultant

Composition
Integrated Health Services Plan & Community Engagement
Geographic Team for Chetham-Kent

Category	Name	Title/Affiliation
Hospital	Ken Tremblay	CEO, Chatham Kent Health Alliance
Community Care Access Centre	Betty Kuchta	CEO, CCAC
Mental Health	Len Caro	CEO, CMHA-WECB
Community Agency	Jane Hobbs	Ontario March of Dimes
Municipality	Anne Coulter	General Manager, Municipality of Chatham-Kent
Physician	Dr. John Button	Ridgetown
Citizen (Urban)	Karen Kirkwood-Whyte	Executive Director, United Way
Francophone Representative	Janine Griffore	Director of Education, Catholic Francophone Board
Aboriginal Representative	Pat Johnson	Walpole Island
Ministry of Health & Long Term Care (Regional Office) – ex officio	Mary Kay Croft	Program Manager, Long Term Care

Composition
Integrated Health Services Plan & Community Engagement
Geographic Team for Windsor-Essex

Category	Name	Title/Affiliation
LHIN Board Member	Leland Martin	Director
Hospital	Warren Chant	CEO, Leamington District Memorial Hospital
Community Care Access Centre (1)	Mary Wilson	CEO, CCAC
Mental Health	Pam Hines	CEO, CMHA-WECB
Community Agency	Hildegard Ashe	ED, Sandwich CHC
Municipality	Dr. Alan Heimann	Medical Officer of Health
Physician	Dr. Arthur Kidd	Chief of Staff, Hotel Dieu Grace Hospital
Physician	Dr. Ian McLeod	
Citizen (Rural)	Victor Gabriele	Leamington
Citizen (Urban)	Barb Bjarneson (Chair)	Windsor
Francophone Representative	Nil Parent	Citizen
Ministry of Health & Long Term Care (Regional Office) – ex officio	Anthony Sirizzotti	Hospital Consultant

Composition
Integrated Health Services Plan & Community Engagement
Steering Committee

Category	Name	Title/Affiliation
LHIN Board Member	David Wright	Vice-Chair
CK Team Rep	Betty Kuchta	CEO,CCAC-SL, /CK
WE Team Rep	Barb Bjarneson	Citizen
Hospital	Martin Girash	CEO Windsor Regional Hospital
Education & Training	JoAn Dale	Chair, Health & Community Studies, St. Clair College, Thames Campus
Mental Health	Judy Watson	CMHA Provincial board
Community Agency	Carol Derbyshire	ED, Hospice Windsor (Chair)
Physician	Dr. B.Gamble	Chatham
Physician	Dr. N. Ali	Sarnia
Citizen (Rural)	John Palcit	Amherstburg
Citizen (Urban)	Tom McCarthy	Chatham
MOHLTC (Regional Office) – ex officio	Anthony Sirizzotti	Hospital Consultant
Tertiary Acute Care	Patricia Potter	Integrated Strategic Alliances and Networks
IT/IM Team Rep	Sharon Pfaff	CIO, Chatham-Kent Health Alliance
SL Team Rep	Cindy Thayer	General Manager, County of Lambton
Hospital	Pat Somers	Hotel Dieu Grace Hospital-Chief Nursing Officer

Exhibit F

Decision Support Team

Members of the Erie St. Clair Local Data Management Partnership, which is comprised of representatives from the five hospitals and the CCAC's in ESC LHIN, as well as the Data Management Coordinator from the MOHLTC agreed to take on an additional role as the Decision Support Team for the ESC LHIN.

Team Members:

Kathy Breault	Bluewater Health
Karen Waymouth	Chatham-Kent Health Alliance
Sheila Arpan/Alison Anderson	Hotel Dieu Grace Hospital
Janet Bayley/Sarah Padfield	Leamington District Memorial Hospital
Julie Durocher	Windsor Regional Hospital
Vicki Harkness	Chatham-Kent and Sarnia Lambton CCAC
Mary Ann Hamelin	Windsor-Essex CCAC
Sandra Lariviere	Data Management Coordinator

APPENDIX G

STRATEGIC INTEGRATION DIRECTION ACTION PLANS

APPENDIX G

STRATEGIC INTEGRATION DIRECTIONS

APPENDIX G

Introduction

Eight Strategic Integration Directions (SIDs) have been identified through a process which incorporated information from a variety of sources including community consultation, data analysis, provincial goals and objectives, as well as prior planning reports. A more complete description of the process is provided elsewhere in the Report. The eight SIDs are:

1. **Chronic Disease Management** **2**
2. **Reduce Dependence on Hospital Based Services** **10**
3. **Supporting People at Home** **17**
4. **Back Office/Administration Integration** **23**
5. **System Navigation** **30**
6. **Health Human Resources** **35**
7. **Health Promotion and Illness Prevention** **49**
8. **Timely Access to Appropriate Care and Services** **38**

In this section of the Report, a description of each SID is provided, followed by a summary of supporting data, current relevant provincial and LHIN activities, description of the specific Strategic Projects to promote the direction and the related Enabling Projects which the LHIN will support.

The Strategic Projects will be undertaken by the Erie St Clair LHIN over a three-year period, and an overview description of each project is provided including outcomes, deliverables and measures of success. However it is important to note that when a project is initiated a more detailed project specific work plan will be developed which will include the following major planning steps:

- Description of specific objectives, outcomes and timetable
- Steering committee terms of reference and a detailed planning process
- Communications strategy
- Updated Environmental Scan
- Data analysis
- Model development
- Recommendations and next steps
- Implementation plan

Enabling projects were identified through a survey which asked agencies and service providers in the LHIN to identify current integration activities or projects. Projects were selected which supported the Strategic Integration Direction, identified integration as a priority, and might benefit from short term support by the LHIN.

To move forward with the various projects, the LHIN will build on existing groups and networks, and/or help establish new ones as required. Initial suggestions for Networks include Emergency Medicine, Paediatrics, Psychogeriatric/Alzheimers. Service integration will be the underlying and central theme of all projects and collaboration between and among agencies, services and practitioners will be fundamental to success.

1. Strategic Integration Direction – Chronic Disease Management

Description

A chronic disease is a long-term condition that cannot be completely cured but can be managed to prevent or slow progression. A growing number of people aged 45 and older are now living with chronic illness, e.g.

- Almost 34% have arthritis
- 30% have high blood pressure
- 12% have osteoporosis
- 9% have diabetes
- 8% have asthma
- 6% suffer from depression
- 4% have been diagnosed with cancer
- 2% are currently living with the effects of stroke

Chronic disease has a profound effect on one's physical, emotional, and mental well being. Chronic disease management often makes it difficult for people to carry on with daily routines and relationships, and affects their quality of life. If left unmanaged, chronic illnesses may cause pain. Furthermore, chronic diseases rob people of their mobility and independence, and affect their ability to enjoy life. In extreme cases, chronic disease may also lead to other diseases and death. For example, according to the Institute for Clinical Evaluation Sciences, in Ontario, diabetes is responsible for 25 to 33 per cent of heart attacks, 43 per cent of cases of heart failure, 30 per cent of strokes, 64 per cent of amputations, and 51 per cent of new referrals for dialysis annually.

Chronic disease management is a pro-active, population-based approach that addresses chronic diseases early in the disease cycle to prevent disease progression and reduce potential health complications. Multiple

strategies are used to improve the health of all patients diagnosed with specific conditions. A chronic disease management approach reduces the need for future acute interventions and allows people to maintain their independence and health for as long as possible. Chronic disease management approaches must involve all components of the service continuum. Integrated strategies based on common principles and protocols are required. These strategies need to differentiate the roles of agencies and practitioners to produce a coordinated and effective system for the management of chronic diseases.

Current Activities

Many chronic diseases can be prevented when people have the support they need to make healthy choices and lead healthier lives. With healthy eating, regular exercise, not smoking and effective stress management, over 90 per cent of type 2 diabetes and 80 per cent of coronary heart disease could be avoided (WHO). A tobacco-free society would prevent more than 90 per cent of lung cancer deaths and 30 per cent of all other cancer-related deaths (Statistics Canada).

Although the leading causes of death in Ontario are cancer, cardiovascular disease, stroke and diabetes, the actual underlying causes of those diseases and deaths are, very often, tobacco and alcohol use, poor diet and lack of physical activity.

Some of the complications, (e.g. illness and death) caused by chronic disease could be prevented through early detection and treatment. For example:

- If 70 per cent of women aged 50 to 69 had regular mammograms, more breast cancer could be detected earlier and treated successfully, and the number of deaths from breast cancer would drop by 30 per cent over 10 years. (Cancer Care Ontario)
- If Ontarians aged 50 to 75 received regular colorectal screening by fecal occult blood testing, more would receive early treatment and deaths from colorectal cancer could drop by 15 to 33 per cent (National Committee on Colorectal Cancer Screening)

Once a person has a chronic illness, the condition cannot be cured, but it can be effectively managed. With the right treatment and support, people diagnosed with a chronic disease can improve their health, reduce their pain and discomfort, and enjoy life. For example:

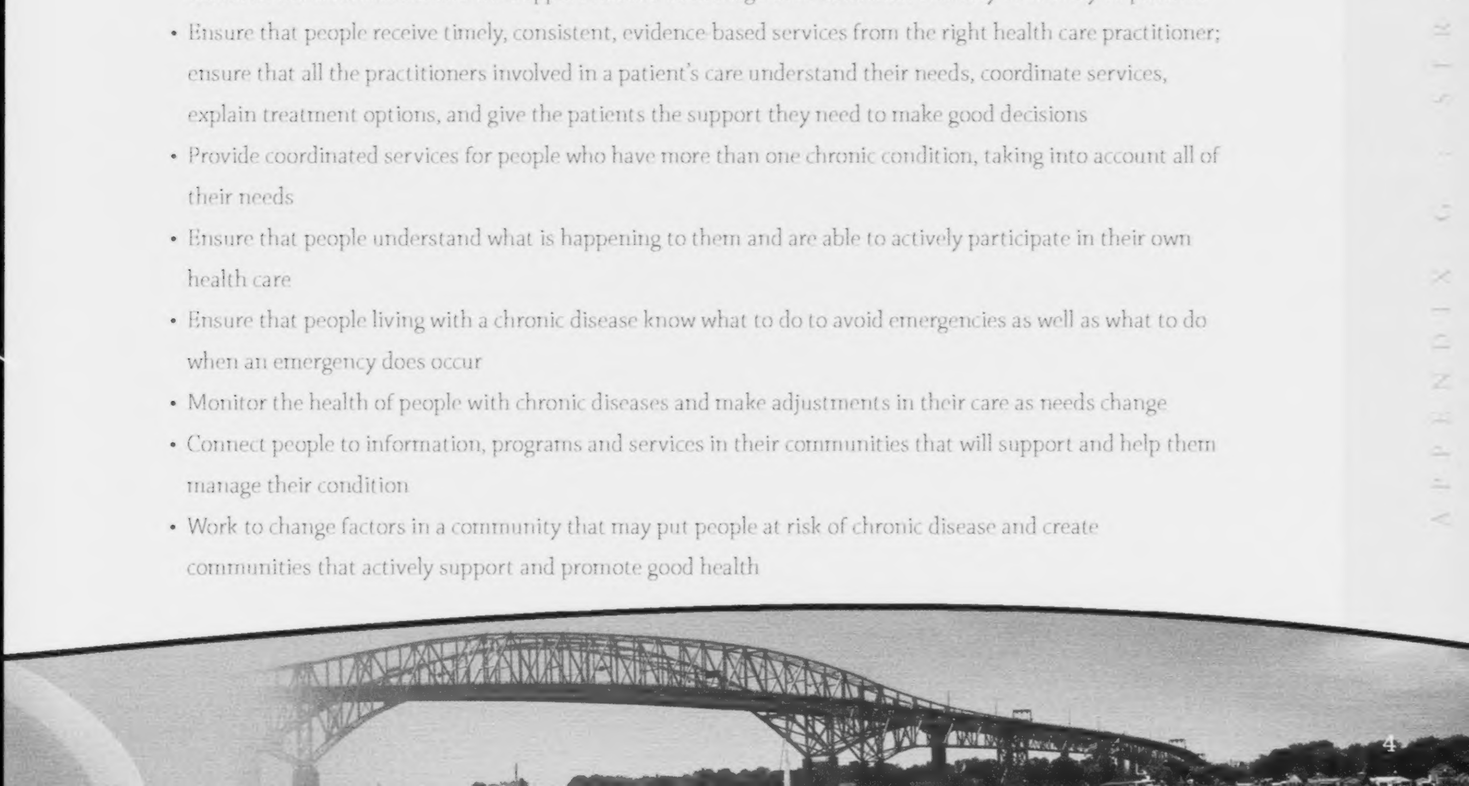
- People with diabetes who attended an interdisciplinary, community based self-care clinic experienced an average 14 per cent drop in blood glucose levels within one year (London Inter Community Health Centre)
- Individuals who participated in a congestive heart failure discharge program that coordinated care and provided education for them and their families had 68 per cent fewer re-admissions to hospital (Group Health Centre, Sault Ste Marie)

Chronic disease is different from the acute illnesses that the health system is used to treating. Acute illnesses tend to be short and episodic. They occur, are diagnosed, treated and often cured. In the classic acute care model, a single provider is often responsible for delivering care, and the person being treated is primarily a receiver of services. The care is reactive and it tends to be resource intensive and expensive.

By contrast, people can live many years with a chronic illness. The condition, its symptoms and its treatment become part of their lives. They must deal with changes in the disease over time, as well as the impact on their family and friends. The goal in treating chronic disease is to reduce and control symptoms, and to help people lead as healthy a life as possible. In an effort to maintain their health, people with chronic conditions may have ongoing contact with a number of different health practitioners. As a result, they often become very knowledgeable about the effects of the disease, and the choices they make have a significant impact on their health and their care.

Preventing and managing chronic disease requires a fundamental change in the way care is provided. A movement toward a more integrated systems approach that focuses on the person, not the disease is needed to:

- Engage healthy people, those with risk factors, and people with a chronic disease in improving and managing their own health
- Give people the information and support needed to promote their health and avoid illness
- Identify people at risk and diagnose people who develop a chronic condition early; provide them with easy access to the information and the support needed to manage their condition and stay as healthy as possible
- Ensure that people receive timely, consistent, evidence-based services from the right health care practitioner; ensure that all the practitioners involved in a patient's care understand their needs, coordinate services, explain treatment options, and give the patients the support they need to make good decisions
- Provide coordinated services for people who have more than one chronic condition, taking into account all of their needs
- Ensure that people understand what is happening to them and are able to actively participate in their own health care
- Ensure that people living with a chronic disease know what to do to avoid emergencies as well as what to do when an emergency does occur
- Monitor the health of people with chronic diseases and make adjustments in their care as needs change
- Connect people to information, programs and services in their communities that will support and help them manage their condition
- Work to change factors in a community that may put people at risk of chronic disease and create communities that actively support and promote good health



Current Activities

Many organizations, agencies and practitioners in the LHIN understand the benefits of effectively managing chronic diseases and are actively implementing positive strategies. Various disease-focused groups have come together for support, to share information, and to develop common approaches to disease management. The Population Health Policy Unit of the Ministry of Health and Long-Term Care, through its Chronic Disease Program Management Transformation Project Steering Committee, has developed an evidence-based, priority setting decision tool for chronic diseases. Also, the Ministry is developing a framework for chronic disease management, which will provide guidance for LHIN planning.

Rationale

Chronic disease prevention is strongly related to controllable factors related to lifestyle. Prevention is also affected by appropriate access to health care services and professionals.

Information specifically related to chronic diseases management is taken from the Canadian Community Health Survey, 2005, as shown in the table below (note - this was a self-report survey). The data should estimate utilization data, but may not if persons are unaware of a disease, or choose not to reveal it to surveyors. The figures in the "Ratio to Ontario" show the ratio between the percentages reported in each area (Chatham-Kent, Essex, or Lambton) with the percentage reported for Ontario. The "Change to Meet Ontario" column shows the number of additional/fewer people who would be needed to match the Ontario percentage. The "Impact" column highlights whether the corresponding percentage reflects a positive (++) impact on area health, or negative (--).

Table XX: Selected Responses from CCHS Related to Chronic Diseases Management

	Chatham-Kent				Essex				Lambton			
Self Reports:	**Current**	**Ratio to Ontario**	**Change to Meet Ontario**	**Impact**	**Current**	**Ratio to Ontario**	**Change to Meet Ontario**	**Impact**	**Current**	**Ratio to Ontario**	**Change to Meet Ontario**	**Impact**
Does not have a regular medical	5,855	0.73	2,261	++	41,676	1.39	(11,570)	–	6,856	0.70	2,884	++
With arthritis or rheumatism	17,438	1.11	(1,708)	–	70,437	1.21	(12,086)	–	26,790	1.42	(7,912)	–
With diabetes	5,716	1.29	(1,284)	–	17,837	1.08	(1,396)	–	6,185	1.17	(866)	–
With asthma	9,467	1.29	(2,142)	–	25,931	0.95	1,243	++	10,809	1.23	(2,017)	–
With high blood pressure	16,410	1.18	(2,409)	–	57,028	1.10	(5,092)	–	19,144	1.14	(2,341)	–

Statistics Canada, Canadian Community Health Survey (CCHS 3.1), 2005 4th series

Observations

Positive influence on chronic disease management:

- Fewer persons in Chatham-Kent and Lambton reported having no regular family doctor compared to Ontario overall
- Fewer respondents in Essex report having asthma

Negative influence on chronic disease management:

- 1.11 to 1.42 times as many reported arthritis/rheumatism
- 1.08 to 1.29 times as many reported diabetes
- 1.23 to 1.29 times as many reported asthma
- 1.10 to 1.14 times as many reported high blood pressure

Ambiguous influence on chronic disease management:

- General practitioner and specialist physician rates are significantly lower in all three areas than across Ontario, in spite of the responses regarding a regular physician in Chatham-Kent and Lambton

The table below shows a comparison of Potential Years of Life Lost (74 age at death) for all causes. Each LHIN area lost significantly more years of life per capita between 1999 to 2001 than did the rest of Ontario. Again, Ontario is not the benchmark for success. The key observation is that LHIN residents lose more years of life than Ontarians overall.

Potential Years of Life Lost, 1999-2001 averaged*

Age-standardized rate/1,000

	All Causes					
	All		Males		Females	
Planning Area	Ave Rate	Sign Diff	Ave Rate	Sign Diff	Ave Rate	Sign Diff
Chatham-Kent	5,953	↑	7,462	↑	4,431	↑
Essex	5,031	↑	6,048	↑	3,983	↑
Lambton	5,599	↑	6,964	↑	4,231	↑
ESC LHIN	5,310	↑	6,481	↑	4,114	↑
Ontario	4,755		5,829		3,679	

*Statistics Canada, Health Indicators January 2005

A review of specific causes of death show that LHIN citizens lost:

- 32% of Potential Years of Life Lost to all types of cancer
- 18% of Potential Years of Life Lost to all types of circulatory disease (including heart and stroke)
- 12% of Potential Years of Life Lost to ischaemic heart disease

LHIN areas were significantly higher than Ontario in all three of the above disease categories.

The precursors to many types of cancers and circulatory diseases (although genes and the environment do play a part) are lifestyle choices of a long-term nature.

LHIN Projects Summary Table

Strategic Projects (1 to 3 years)

1. LHIN to develop a chronic disease management strategy
2. LHIN to support a diabetes network

Current Enabling Projects

1. Arthritis Planning Group
2. Community Geriatric Assessment Network
3. Diabetes Virtual Access Centre

Action Plans for each Project

Project 1: Develop a LHIN-wide Chronic Disease Strategy

Description

The number of people suffering from chronic diseases is increasing. The treatment and follow up of those with chronic diseases is not uniform. If left untreated or not managed properly, chronic diseases can negatively affect quality of life and lead to other diseases. A strategy for managing chronic diseases would establish common principles and values, formalized protocols based on best practices, definition of roles and relationships, etc., to promote a systematic approach to the management of chronic diseases.

Outcomes

- Improved early detection and follow up for patients
- Improved mobility and quality of life for those people with chronic disease
- Improved health status
- Reduced utilization of some acute health services

Year 1 – Deliverables

- Establish and resource a working group to lead the process
- Conduct an environmental scan and analysis of need, including a review of the population data and service inventory to determine the scope of the issue, priority populations and existing chronic disease management activity
- Conduct a literature and best practices review to collect, consolidate and analyze relevant research and experience, and identify appropriate models, protocols, etc., that could be used, or modified in the strategy
- Consult with providers and consumers to provide an opportunity for all interested agencies, practitioners, consumers and families to provide their input, experience and expectations

- Conduct a survey to gather additional information and to test assumptions and potential actions prior to developing a plan
- Make recommendations including preferred models and prioritized diseases for staging implementation and an implementation plan

Year 2 – Deliverables

- Initiate the implementation plan for the chronic disease management strategy
- Establish disease-specific implementation teams of experts to decide upon the appropriate actions for rolling out the chronic disease management strategy for top priority diseases
- Develop practice guidelines that will enable agencies and practitioners to implement the strategy consistently
- Provide education for the chronic disease management strategy to providers and consumers, highlighting the strategy, implications and the implementation process

Year 3 – Deliverables

- Continue to support Year 2 implementation and initiate the next priority diseases
- Repeat Year 2 actions for new disease priorities

Measures

- To be determined

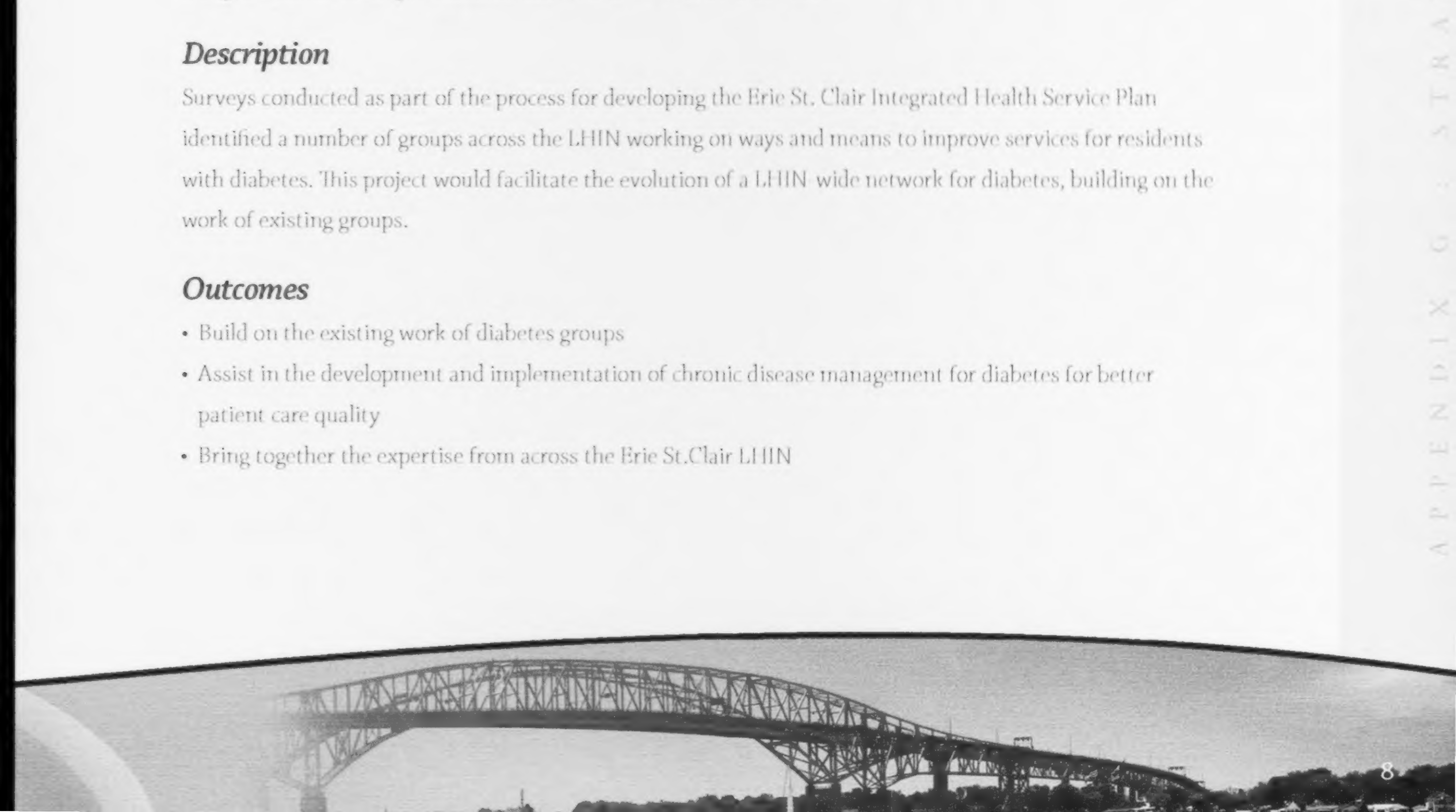
Project 2: Develop a LHIN-wide Diabetes Network

Description

Surveys conducted as part of the process for developing the Erie St. Clair Integrated Health Service Plan identified a number of groups across the LHIN working on ways and means to improve services for residents with diabetes. This project would facilitate the evolution of a LHIN-wide network for diabetes, building on the work of existing groups.

Outcomes

- Build on the existing work of diabetes groups
- Assist in the development and implementation of chronic disease management for diabetes for better patient care quality
- Bring together the expertise from across the Erie St.Clair LHIN



Year 1 – Deliverables

- Establish a lead group to conduct a one day workshop on diabetes to initiate discussions
- Develop a workshop agenda, including the identification of objectives, format topics, issues, speakers, etc., for the workshop

Year 2 – Deliverables

- Formalize and support a LHIN wide Diabetes Network, including the establishment of the membership, mandate and terms of reference, including a mandate to assist in the establishment of a chronic disease management program

Year 3 – Deliverables

Measures

- Reduced visits to emergency departments
- Reduced admissions to hospitals
- Reduced potential years of life lost

Enabling Projects

1. *Arthritis planning group*

The Arthritis Society is collaborating with other service providers outside this LHIN to improve services for people with arthritis and would like to work with other partners in the LHIN.

2. *Geriatric assessment networks*

Several existing groups are focused on improving geriatric assessment services in the LHIN. These groups would benefit from LHIN support, as a facilitator for moving forward across the LHIN.

3. *Diabetes groups network*

A number of groups and networks for diabetes exist within the LHIN. Each is working to improve access to, and the quality of services. These groups would benefit from LHIN administrative and facilitation support, to bring the groups together to share expertise and experiences and provide a critical mass of interest to move forward with chronic disease management strategies.

2. Strategic Integration Direction – Reduce Dependence on Hospital Services

Description

Hospital based services are often the most complex and expensive in the system. Sometimes, hospitals provide services because appropriate alternatives are not available in the community. When primary care services are not available, or accessible in a timely manner, hospital emergency services might be the only care alternative. Also, patients might sometimes spend too much time in hospital beds and cannot be discharged, because non-hospital services are not available, or the patient must wait for services to become available in the community. A recent Canadian Institute for Health Information (CIHI) survey entitled, "Alternatives to Acute Care," found that 19 per cent of all Alternative Level of Care (ALC) patients are discharged from hospital back to their communities and homes without any supports. Unnecessary hospital usage can contribute to delays in access and treatment for acute patients and overcrowding in emergency departments. People are also living longer with chronic conditions that could be more effectively and efficiently supported by community services, which focus on preventing or reducing the need for hospitalization. The system cannot afford the current, growing demand for hospital services. Integrated strategies are needed to reduce the strain on hospital services, by providing community based alternatives when and where appropriate.

Challenges & Benefits

Currently, there are no recognized, evidence based guidelines for hospitalization, admissions to intensive care, or referral to medical specialists. As well, there is no direction for ordering diagnostic tests for patients at any stage of a chronic illness. Without these guidelines, the following two factors most frequently drive decisions:

- Both physicians and patients generally believe that more services produce better outcomes
- Based on the previous assumption, the supply of resources, not the incidence of illness, drives utilization of the services. In effect, the supply of hospital beds creates its own demand, so areas with more resources per capita tend to have higher costs per capita

These issues speak to the need to invest in care outside of the hospital. A major challenge will be to develop a reimbursement system that rewards, rather than penalizes, facilities that successfully reduce unnecessary services.

The benefits of reduced dependence on hospital services include:

- Increased access to local community services
- More support in the community to assist citizens to make healthy choices
- More appropriate treatment for the chronically ill

- Cost savings to the acute care system and improved sustainability
- Reduced wait times for some services
- Increased promotion of services that encourage independence
- A more responsive health care system
- Better use of specialists, diagnostic imaging and specialized bed units (ICU)
- A more integrated approach to care provision

Current Activities

Many health care reports indicate that there is an over dependence on the acute hospital sector in Ontario, which is not sustainable in the future. Currently, smaller hospitals are having difficulty sustaining service levels, due to an aging workforce and costly advances in medicine and technology. Also, the changing demands and needs of the population, especially related to acceptable wait times for care, the need for safe, high-quality treatment, and improved local access necessitate more integrated approaches to care delivery.

The Ministry has established some formal mechanisms in certain areas to reposition the role of the hospital in the context of the wider community. In the area of mental health care, a provincial working group was established to develop principles and provide strategic implementation advice to help guide the appropriate transfer of non-bedded mental health programs and services from affected hospitals to non-profit community agencies. The main purpose of the working group is to ensure that a consistent approach is taken across the province to the transfer of responsibilities from affected hospitals to community agencies.

At the LHIN level, a number of processes and formal groups are being established to discuss and identify opportunities for improved integration and to clarify roles between the hospital and community service sectors. In the Windsor-Essex area, a system coordination group, comprised of the hospital CEOs, senior management from the CCAC, CMHA, long-term care facilities, the hospice, the public health unit and the LHIN has been meeting to advance a strategic planning framework that will be common to all partner agencies. This will help to promote information sharing, collaboration, and role clarification and will result in a more seamless system of care in the area. Similar discussions are occurring across the LHIN.

Rationale

- Erie St. Clair LHIN Alternate levels of Care (ALC) statistics identify 19% of all ALC patients are discharged from hospital without home support
- Some patients may not require hospitalization
- Excessive length of stay and conservable days statistics appear high
- Community engagement participants identified needs for more community care and home-based services

LHIN Projects Summary Table

Strategic Projects (1 to 3 years)

1. LHIN to support and facilitate planning for mental health system (Tier II & Tier III) divestment with a focus on appropriate hospital and community based services
2. LHIN to identify strategies for resolving issues related to alternate level of care
3. LHIN to develop strategies to support the appropriate use of hospital emergency departments

Current Enabling Projects

1. In-Patient Psychiatric Discharge Program (CMHA & HDGH)
2. Concurrent Disorders Network (Sarnia-Lambton, Mental Health & Addictions)
3. Mental Health Collaboration Committee

Action Plans for each Project

Project 1: We will support and facilitate planning for Mental Health System Tier II & Tier III divestment, with a focus on appropriate hospital and community-based services.

Description

Tertiary psychiatric bed based services and associated non-bedded services are to be transferred from St. Joseph's Health Centre London to Windsor Regional Hospital, as part of the Tier II and III strategies. This transfer process provides an opportunity to develop and implement strategies to improve the alignment and configuration of hospital and community-based services across our LHIN. We will support and facilitate the associated planning necessary to produce an efficient and effective mental health system.

Outcomes

- Improved communications between hospital and community sector mental health care providers
- Establishment of consistent operation protocols, policies/procedures across the mental health system
- Establishment of a formal mechanism for conflict resolution between the involved parties
- Establishment of a standard strategic planning framework for mental health services system wide
- Improved access to a seamless system of comprehensive mental health services across the region

Year 1 – Deliverables

- Establish a working group for mental health divestment
- Develop a divestment plan for non bed based mental health services

Year 2 – Deliverables

- Mental health system design report
- Identification of areas that could benefit from formal operating agreements between mental health system providers to support a seamless continuum of care

Year 3 – Deliverables

- Mental health system design implementation plan
- Mental health system communications strategy
- Formal operation agreements among organizations
- A monitoring and evaluation process

Measures

- Number of formal operating agreements developed among mental health providers
- Improved access to mental health services in the community
- Faster access to mental health services
- More responsiveness/streamlined care pathways
- Fewer delayed hospital discharges
- Increased opportunities for shared resources
- Higher level of client satisfaction

Project 2: We will to identify strategies for resolving issues related to Alternate Level of Care

Description

Alternate Level of Care (ALC) cases are those where a patient is ready for discharge from an acute care hospital bed, but the required alternate level of service is not immediately available. The patient must unnecessarily occupy an acute hospital bed, when their needs could be better met in a less costly alternative setting such as a long-term care facility, but there is a waiting list. ALC days are considered an inefficient use of acute care resources and reflect problems with access to post-acute services such as rehabilitation, long-term care homes, home care, etc. A recent CIHI survey, "Alternatives to Acute Care," found that 19 per cent of all ALC patients are discharged from hospital back to their communities and homes without any support whatsoever.

We will establish an ALC working group to conduct a review of patients awaiting transfer from ALC, to enhance understanding of patient flow issues/needs, identify patient populations experiencing difficulties accessing community supports, and determine how to improve access to the needed supports.

Outcomes

- Minimize the overall number of ALC days in the Erie St. Clair LHIN
- Improve access to community support for ALC patients
- Enhanced understanding of patient flow issues across the care continuum
- Development of a standard ALC definition and consistent use of this definition throughout the Erie St. Clair LHIN area
- Increased system flexibility to accommodate periodic increases in ALC demand and utilization related to exceptional circumstances (e.g. flu season)

Year 1 – Deliverables

- Establish a working group for ALC issues
- Produce a report on issues and solutions for reducing ALCs

Year 2 – Deliverables

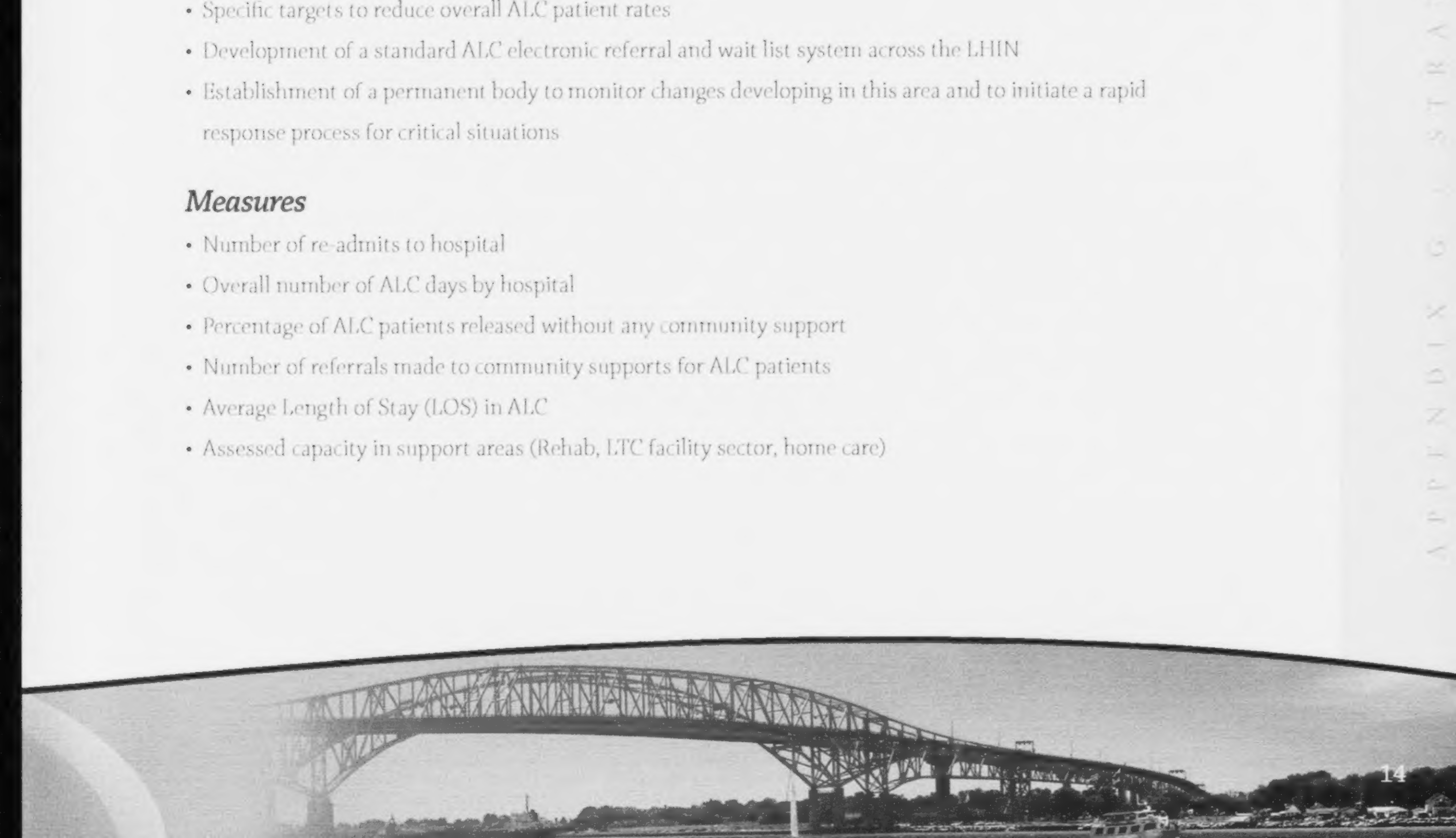
- Implementation plan that addresses ALC issues and strengthens communications and integration practices between hospital and community support services
- Specific improvements in the referral and response process for ALC patients

Year 3 – Deliverables

- Development of a system-wide ALC communications plan
- Specific targets to reduce overall ALC patient rates
- Development of a standard ALC electronic referral and wait list system across the LHIN
- Establishment of a permanent body to monitor changes developing in this area and to initiate a rapid response process for critical situations

Measures

- Number of re-admits to hospital
- Overall number of ALC days by hospital
- Percentage of ALC patients released without any community support
- Number of referrals made to community supports for ALC patients
- Average Length of Stay (LOS) in ALC
- Assessed capacity in support areas (Rehab, LTC facility sector, home care)



Project 3: We will develop strategies to support the appropriate use of hospital emergency departments

Description

Over the past decade, there has been a 40 per cent decrease in hospital bed capacity in Canada. An aging population, increased numbers of homeless and de-institutionalized people, and emerging infectious diseases are all straining the capacities of emergency medical staff.

The inability of emergency patients to access hospital beds is a major issue currently facing emergency departments in Ontario. The lack of access to primary care services also puts pressure on the emergency department. There is a clear need to reduce emergency department length of stay for patients, but most of the solutions lie beyond the emergency department. Emergency departments alone cannot address these significant issues. Unless practices change, the emergency departments will not function in their designated role, and will instead inappropriately provide care to patients who should be in inpatient beds, or who require access to primary care services.

A working group will be created to identify and implement strategies to use emergency department resources more effectively.

Outcomes

- More appropriate use of emergency department by LHIN residents
- Improved patient flow within hospital and between hospital and community sectors
- Safer, less-crowded emergency department environment
- Alternatives to emergency department for primary care
- Increased patient satisfaction with emergency departments
- Removal of barriers to emergency care

Year 1 – Deliverables

- Establish a working group for emergency department services
- Work with Southwest Emergency System Network Coordination
- Create an issues and solutions report for reducing emergency department utilization

Year 2 – Deliverables

- Develop an implementation plan to improve emergency department operations
- Develop a workforce issues plan

Year 3 – Deliverables

- Advance a public education strategy on emergency department usage
- Develop and apply specific targets to improve emergency departments throughput

Measures

- Number and percentage of patients who leave the emergency department without being treated
- Average length of stay/wait in emergency department
- Number of patients accessing emergency department/yearly (per cent increase)
- Number and percentage of unattached patients (no family physician)
- Number of complaints received related to emergency department service
- Number of violent incidents affecting emergency department staff
- Number of patients who die while in emergency department
- Percentage of patients waiting in emergency department for inpatient bed/average length of wait
- Number and percentage of patients deemed non-urgent

Brief Description of Enabling Projects

Enabling Projects

1. In-Patient Psychiatric Discharge Program

The Canadian Mental Health Association (CMHA) and Hotel-Dieu Grace Hospital in Windsor, are looking at establishing a formal discharge process operating agreement from Schedule I mental health acute hospital beds that better integrates hospital in-patient mental health services with community support services. The agreement would ensure that:

1. There is better continuity of care between the hospital and community
2. A discharge team is in place to develop an improved, more comprehensive discharge plan for hospital in patient mental health patients
3. When possible, patients are discharged sooner to community (reduced dependence on hospital services) with appropriate support

LHIN staff may help to advance this process by meeting with both organizations to review progress and discuss next steps needed to develop/finalize the operating agreement.

2. Concurrent Disorders Network – (Sarnia-Lambton, Mental Health & Addictions)

Approximately eight years ago, CMHA Lambton and Bluewater Health agreed to share the responsibility for leading a network of a broad range of service providers involved with clients with a concurrent disorder (mental illness and addiction problem). The key objectives of the network were to develop a model to ensure integration of the mental health and addiction services, facilitate communications and continue staff development.

Approximately six years ago CMHA and Lambton Addictions Services (Bluewater Health) developed and co-facilitated a concurrent disorders treatment group. This group has continued to thrive as a joint venture. On August 13, 2006, the CMHA was informed that Bluewater Health would no longer be involved with this initiative undertaking, effective August 31, 2006, due to a reduction in staffing related to budget constraints and a need to refocus on core hospital services.

The LHIN staff could become involved with the Lambton Concurrent Disorders Treatment Group, to review the work that has been done in this area and assess the community capacity and readiness to deliver better integrated services in the areas of mental health, addictions, and problem gambling. It could also assist to review/develop opportunities that support further developments this direction.

3. Mental Health Collaboration Committee

Recently, a mental health collaboration committee was formed in Windsor-Essex County between the CMHA and three area hospitals (Hotel-Dieu Grace Hospital, Windsor Regional Hospital, Leamington District Memorial Hospital) to identify opportunities for improved integration across the mental health system. This group is in the process of completing a detailed memorandum of understanding to guide decision making in this area. Responsibilities of the group will include:

1. Developing operational protocols, policies and procedures among the involved parties
2. The promotion of a client-centred, seamless mental health system
3. Clarification of which organizations will operate what programs, and how they are to be linked across the broader mental health system
4. Monitoring performance in the mental health system

The LHIN could help to advance this process, by reviewing progress and next steps to develop/finalize the memorandum of understanding.

3. Strategic Integration Direction – Supporting People at Home

Description

The Province of Ontario has actively supported home care for more than 30 years. The service began as a limited in-home health service, provided primarily on a post-acute basis. During much of the period, services were limited to frail, elderly people. Those who were unable to live independently utilized homes for the aged, nursing homes and rest and retirement homes.

In the 1980s, a shift in community attitude resulted in more elderly people choosing to remain in their own homes, instead of entering institutions. By the late 1980s, the Ontario government gave formal recognition to homemaking after a hospital stay, as a service required by many elderly people to maintain community living.

The fiscal pressures on governments in the early 1990s resulted in the closure of a significant numbers of hospital beds and reductions in lengths of stay. This resulted in a dramatic increase in the number of referrals to the home care system. In order to manage these pressures, in 1996 the Ministry announced its intention to establish Community Care Access Centres (CCACs) across Ontario. This new direction would assume responsibility for home care, facility wait lists management, placement in a long-term care facility, and the development of a coordinated health information and referral service. Currently, each CCAC helps senior clients to navigate Ontario's complex health system and to better meet their needs through the alleviation of barriers to service and service gaps.

Institutional services are in great demand and are a very necessary and costly part of our health care system. Programs and services that assist people to remain at home longer or to leave bed-based services sooner, can relieve the pressure on, and demand for institutional care. These services can also improve the effectiveness of informal supports, as well as the health and quality of life of individuals. Integration strategies are required to promote efficient, effective and timely home support services.

Challenges & Benefits

The long-term care system and community-based care sector are large complex configurations of services that have developed over a relatively short period of time. As the long-term care system continues to grow and change, new challenges arise, which will provide ample opportunity for new planning initiatives. Workforce shortages, questions about how to measure and deliver quality care, and financing are among the central challenges facing this sector. These challenges will be exacerbated as the population ages. The number of people aged 85 and older (those most likely to require support at home) will double by 2020.

The benefits of supporting people at home are

- Increased independence in the senior population
- More responsive to seniors' needs and wishes
- Ensuring the availability of a well-resourced, coordinated, community-based service system
- Better and more timely access to the community-based service system
- Fewer people falling through the cracks, resulting in fewer crisis situations
- Potential for reduced hospital admissions
- Reduced hospital lengths of stay/earlier discharge with appropriate supports
- Delayed and/or prevented placements in long-term care facilities

Current Activities

Currently, all provinces and territories are increasing expenditures on home and community care systems in response to growing/changing demands that impact this sector. The Ministry of Health and Long-Term Care is developing an "Aging in Ontario Strategy" that seeks to improve health, create more choice and enhance seniors' independence. The rationale supporting this direction is that the population is aging, consumer expectations are changing, there are growing labour shortages on the horizon, chronic disease patterns across the population are increasing, and the elderly are becoming healthier and wealthier.

Past planning reports show that facility-based care is the most expensive and least desired form of long term care. If current service responses continue, even assuming costs were frozen at today's levels (which is unrealistic), long-term care (LTC) costs will rise dramatically just to keep up with population growth. Given this scenario, facility operating costs will rise faster than any other category. The Ministry, in response to this trend, is proposing a strategy that shifts from historic emphasis on supply to an approach more in keeping with seniors' needs and preferences.

The proposed strategy seeks to lower the proportion of dependent seniors and reduce the migration of at-risk seniors into dependency through six key programs:

- Empowering healthy aging – an outreach program that builds awareness of risk factors (e.g. falls, social isolation) and how to avert situations that can lead to crisis and dependency
- Caregiver supports – programs to sustain the ability of caregivers to support their dependent family members
- Technology enabled care – piloting emerging health technologies in seniors' homes
- Home adaptations – that will extend the period of time seniors can maintain their independence in their town homes
- Community-based living environments – incentives that encourage the provision of rental and ownership environments appropriate for the aging population
- Capital renewal for LTC homes – small scale, incremental, voluntary and staged renewal to bring all facilities up to current standards

Rationale

- High volume of acute separations and mental health separations
- High volume of patients awaiting admission to long term care placements
- High ALC days
- Consistency with provincial end of life strategy
- Strong direction from community engagement sessions

LHIN Projects Summary Table

Strategic Projects (1 to 3 years)

1. We will identify integration opportunities and strategies aimed at supporting more people at home

Current Enabling Projects

1. Psycho-geriatric urgent response initiative
2. Shared aftercare model for addictions clients

Action Plans for each Project

Project 1: We will identify integration opportunities and strategies aimed at supporting more people at home

Description

Currently, there are a number of formal groups across the LHIN, involving key long-term care and community health care organizations that meet regularly to share information and discuss issues aimed at supporting people at home. We need to establish a LHIN-wide Long Term Care and Community Care Working Group to oversee and build on the work of these groups. Its role would be to advance best practices, better define roles and responsibilities, identify system issues, and develop options that promote integration across this area.

As the population ages and the demand for service in this area increases, long term care and community care providers will need to be prepared to address these impending changes in a planned and effective manner. A strategic planning process should be initiated and an overall "supporting people at home" framework developed to ensure future success in this area.

Outcomes

- Increased independence of seniors
- Clarification of provider roles and responsibilities
- Improved access to service for seniors at home
- More appropriate and enhanced community supports for patients and family caregivers
- A system that is more responsive to future need/growth
- Increased coordination and integration across this entire LHIN
- Wider development and implementation of best practices for better patient outcomes
- More efficient use of and less duplication of resources

Year 1 – Deliverables

- Establish a Long Term Care and Community Care Working Group to create a strategic framework for issues and solutions for improving support to people at home
- Develop a strategic framework that:
  - Identifies the main (strategic) issues/gaps/needs
  - Assesses system capacity (present and future)
  - Determines what population groups are effected and to what extent
  - Describes what is currently being done to address these issues/needs and what needs to be done strategically
  - Outlines opportunities aimed at improving integration across the LHIN (now and in the future)

Year 2 – Deliverables

- Develop an implementation strategy that identifies actions and resources needed to improve the LHIN and set timelines that are action orientated and anticipate future need/growth
- Advance formal partnership agreements (between provider organizations and professionals) that support improvements and promote coordination in this area
- Advance best practice guidelines that clarify roles and responsibilities
- Implement approved integration opportunities

Year 3 – Deliverables

- Monitor, evaluate, continue to anticipate and respond to changes in this area
- Develop a communications strategy that promotes seniors independence as a viable and desired alternative to institutionalization
- Ensure that the "Supporting People at Home" framework developed in this area is aligned with the Ministry's "Aging in Ontario Strategy"

Measures

- Reduction in crisis (unplanned) admissions to long term care facilities
- Reduced demand for long term care facility beds
- Delayed and/or prevented placements in long term care facilities
- Reduced hospital admissions
- Reduced hospital lengths of stay/earlier discharge with appropriate supports
- Per cent increase in investment in home care resources
- Per cent of Ontarians 75+ living in the community

Brief Description of Enabling Projects

Enabling Projects

1. Psycho-geriatric "urgent response" initiative

The Mental Health Program for Older Adults (MHPOA) in Windsor-Essex County supports a team approach that is co-sponsored and jointly managed by the Canadian Mental Health Association, Windsor-Essex County Branch (CMHA-WECB) and Windsor Regional Hospital's Community Psychiatric Services. The program serves adults 65 years of age and older and has the following goals:

- To improve the mental health of older adults in the community
- To maintain older adults in their own homes as long as possible
- To identify and meet the unique needs of older adults in the community
- To increase public knowledge and change attitudes towards aging and mental health issues

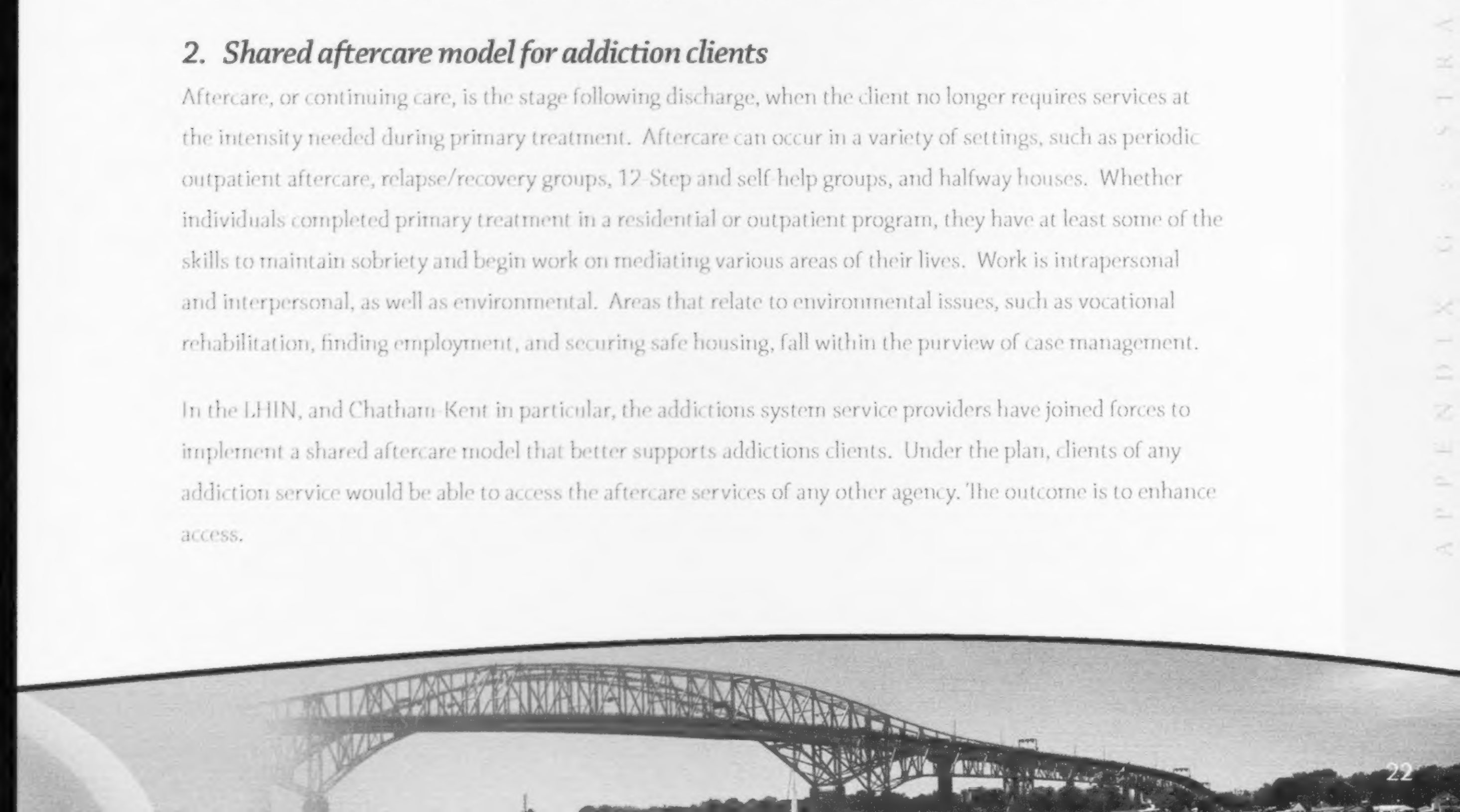
In the Spring of 2006, administrative staff from the joint Mental Health Program for Older Adults met to discuss the need for urgent response capacity/crisis prevention response to be available to seniors to help avert/prevent a crisis event from occurring and/or address the immediate needs of older individuals in crisis. This new program has two interrelated elements: assessment and urgent response/crisis prevention.

We will work with the administrative staff of the MHPOA to determine if this approach is successful (assess measurable outcomes) and if it could have wider application to other homes and/or to the entire LHIN.

2. Shared aftercare model for addiction clients

Aftercare, or continuing care, is the stage following discharge, when the client no longer requires services at the intensity needed during primary treatment. Aftercare can occur in a variety of settings, such as periodic outpatient aftercare, relapse/recovery groups, 12-Step and self-help groups, and halfway houses. Whether individuals completed primary treatment in a residential or outpatient program, they have at least some of the skills to maintain sobriety and begin work on mediating various areas of their lives. Work is intrapersonal and interpersonal, as well as environmental. Areas that relate to environmental issues, such as vocational rehabilitation, finding employment, and securing safe housing, fall within the purview of case management.

In the LHIN, and Chatham-Kent in particular, the addictions system service providers have joined forces to implement a shared aftercare model that better supports addictions clients. Under the plan, clients of any addiction service would be able to access the aftercare services of any other agency. The outcome is to enhance access.



4. Strategic Integration Direction – Back Office/Administrative Integration

Description

This strategy focuses on administrative/back office functions and seeks to achieve efficiencies through technology and administrative integration. The strategic direction also responds to the Ministry of Health and Long Term Care's E-Health Strategic Framework, as an impetus for moving forward. The back office administrative integration strategy has two objectives:

- Reducing costs by eliminating redundant work and infrastructures – By consolidating back office, non revenue generating functions, agencies can take advantage of economies of scale, better utilization of technology and expertise, greater automation, and standardization to achieve higher productivity with fewer resources
- Improving quality – Examples of areas where further integration could be pursued include: quality improvement practices, clinical documentation systems, certification and legal requirements, information systems, purchasing systems, fundraising and communications

The ability to align back office efficiencies with quality improvements is the focus of this strategic direction.

Challenges & Benefits

Government transfer payment agencies today are facing many challenges – limited budgets, the need to modernize, accountability demands, the need to consolidate or optimize infrastructures and the need for improved processes and communications. By implementing shared services solutions, agencies can improve the overall effectiveness and efficiency of their processes by: sharing best practices, specific areas of expertise, enhancing collaboration by making interagency communications better and improving access to information and services. The main benefits of shared services are:

- Shared Services – allow agencies to take advantage of economies of scale, delivering higher quality and productivity with fewer resources. Cost savings, which can be significant, generally come from the elimination of redundant work and unnecessary infrastructure
- Focus on Core Competencies – agencies that participate in shared services are able to spend less time and fewer resources on their own infrastructures, focusing instead on core competencies needed to better serve their clients
- Knowledge Transfer – in agencies that utilize shared services, individuals are no longer relied upon as the single source of information. More than one person has the knowledge required to maintain infrastructure and processes
- An overall enterprising performance by the Erie St. Clair LHIN health service providers

Current Activities

About five years ago, the Ministry of Health and Long Term Care recognized that the health care sector was significantly behind other industries in reaping the benefits of information technology. To address this gap, the Ministry introduced an e-Health Strategic Framework, proposing that by 2015, Ontario would have the safest, highest quality and most sustainable health system in Canada. The vision for Ontario's e-Health system is to ensure the delivery of the right information about the right individual to the right person at the right place at the right time, to enhance health outcomes and improve overall system efficiency.

The Ontario e-Health Strategy is dedicated to harnessing the potential health information technology and informatics towards better health outcomes for patients. Rather than a single project, e-Health in Ontario is evolving as a series of initiatives including:

- Ontario's telemedicine system, allowing patients remote access to health care professionals and specialists that would otherwise involve expensive, long trips
- An extensive electronic Children's Health Network (eCHN), with a database comprised of medical records for over 300,000 Ontario children
- An electronic health record for each person using Ontario's health system, to tie together the pieces of information that constitute an individual's medical history. The record is then transported on the secure, reliable network infrastructure built by Smart Systems for Health Agency that will eventually link all authorized health care providers in the province

Rationale

- Large numbers of small agencies are performing their own back office functions and are funded by the MOHLTC within the Erie St. Clair LHIN
- Many smaller agencies lack necessary infrastructure and expertise to provide cost effective administrative services

LHIN Projects Summary Table

Strategic Projects (1 to 3 years)

1. We will implement an e-Health Strategy
2. We will review progress on supply chain management and Ontario Buys initiative and identify opportunities for expansion in this area
3. We will establish a working group to explore opportunities to better support small agencies (back office) in the context of the wider e-health strategy

Current Enabling Projects

1. Tri-County CMHA Integration initiatives
2. e-Chart Development (WRH, WRCC, Hospice, CCAC)

Action Plans for each Project

Project 1: We will implement an e-Health Strategy

Description

A number of projects involving e-health (that have local implications) are underway in the province, with the overall goal of harnessing the power and efficiency of information management and information technology in order to produce better health outcomes for patients. The MOHLTC is expected to provide renewed strategic direction on this initiative in the fall, which will move this process forward and ensure that Ontario has the safest, highest quality and most sustainable health system in Canada by 2015. Currently, the LHIN will work with local agencies to identify opportunities (such as increased video teleconferencing capacity for expert consultation purposes) that support the goals of the e-health strategy and can be implemented in a timely manner.

Outcomes

- Improved health system performance
- Improved client and patient health outcomes
- Improved service delivery efficiency

Year 1 – Deliverables

- Establish an e-health working group to guide and advise on this project
- Establish a process to gain consensus and commitment to move this project forward
- Receive direction (from MOHLTC) on e-health strategy, directions/priorities, implementation expectations, and targets
- Assess what practices and initiatives are currently being used by local providers
- Ensure that local activities are consistent with provincial e-health strategic directions/framework
- Build on current successes

Year 2 – Deliverables

- Identify potential priority areas (local projects) for e-health strategy advancement
- Identify anticipated impacts of implementing this approach (e.g. technical, financial, human resources, governance issues)
- Develop an implementation plan that outlines the steps, resources, timelines needed to succeed
- Implement plan

- Measure impacts
- Evaluate progress
- Continue to assess ongoing need

Year 3 – Deliverables

- Develop new funding models needed to support the long term implementation of this project

Measures

- To be determined for each outcome area (population health, health system, client/patient, service delivery) for each specific priority area identified in the Year 2 - Implementation Plan

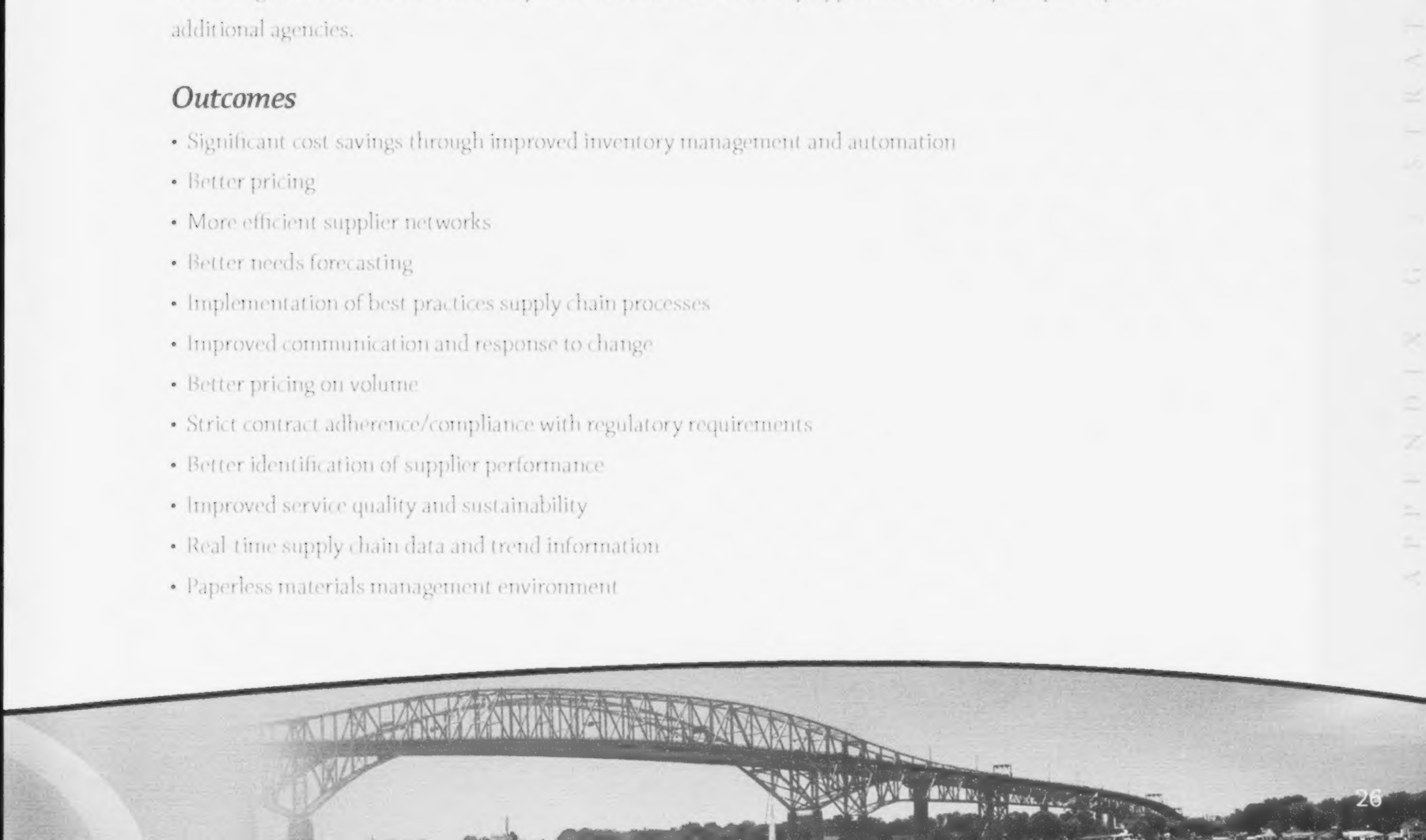
Project 2: We will review progress on Supply Chain Management/Ontario Buys Initiative and identify opportunities for expansion

Description

A number of health care organizations in the Erie St. Clair LHIN are involved with the OntarioBuys initiatives. OntarioBuys is a government initiative, sponsored by the Ministry of Finance, whose mission is to accelerate the widespread adoption of Integrated Supply Chain Management (iSCM) leading practices is Ontario's broader public sector. We will work with providers in our LHIN currently utilizing OntarioBuys to evaluate the savings and efficiencies achieved by these initiatives and identify opportunities to expand participation of additional agencies.

Outcomes

- Significant cost savings through improved inventory management and automation
- Better pricing
- More efficient supplier networks
- Better needs forecasting
- Implementation of best practices supply chain processes
- Improved communication and response to change
- Better pricing on volume
- Strict contract adherence/compliance with regulatory requirements
- Better identification of supplier performance
- Improved service quality and sustainability
- Real time supply chain data and trend information
- Paperless materials management environment



Year 1 – Deliverables

- Develop report on current utilization, costs and benefits of OntarioBuys program in Erie St. Clair LHIN and on the identification of opportunities for expansion
- Work with existing groups to review successes and issues, problems encountered
- Measure/record savings across the health care system resulting from this initiative
- Continue to evaluate the ongoing impact of this initiative
- Overall system modernization plan

Year 2 – Deliverables

- Expand initiative to include a wider spectrum of health care organizations
- Develop a strategy to reinvest money saved back into front-line health system services

Year 3 – Deliverables

- Map a long-term strategic plan that supports this initiative over the next 10 years and aligns with the Ministry strategic plan

Measures

- Total operating cost savings
- Reduced inventory costs (just-in-time systems)
- Quicker ordering capabilities/time
- Time saved by changing to automated systems
- Reduced manual transaction coding errors
- Reduced errors across supply chain cycle
- Material and equipment availability
- Improved forecasting
- Improved staff morale

Project 3: We will establish a working group to explore opportunities to better support small agencies' back office functions in the context of the broader e-Health Strategy.

Description

Currently, some organizations in the LHIN have grouped together to develop an action strategy to realize efficiencies and opportunities for shared services among their organizations. By implementing shared services solutions, agencies can improve their overall effectiveness and efficiency, by sharing best practices, specific areas of expertise, enhancing collaboration by making interagency communications better, and improving access to information and services. Building on the success of larger organizations, opportunities to better support smaller agencies that do not have specialized capacity (expertise) might also be realized, freeing them up to be more involved in the provision of core service. Gains and priority setting in this area should be consistent with the wider MOHLTC e-Health Strategy.

Outcomes

- More efficient use of resources and expertise across organizations resulting in increased productivity
- Reduced duplication in back office functions
- Consolidation of resources, as transaction activities and expert advice are consolidated into a single structure
- Streamlining and standardization of processes
- Improved communications and more timely access to information
- Development of a greater critical mass needed to support expertise of specialized services (e.g. human resources, legal expertise)
- Establish benchmarks/targets for performance
- Staff retraining and redeployment (focus on core business)

Year 1 – Deliverables

- Receive direction (from MOHLTC) on e-health strategy, directions/priorities, implementation expectations, and targets
- Establish a working group to guide and advise in this area
- Identify areas that might benefit from this direction (approaches to shared service) locally (e.g. mental health sector)
- Review what is currently being done in this area (build on successes)
- Assess readiness - determine starting project/area
- Develop principles and overall goals for this initiative and establish parameters
- Assess sector capacity and identify opportunities for shared support

Year 2 – Deliverables

- Identify potential priority areas for shared approach
- Identify anticipated impacts and outcomes of implementing this approach
- Develop shared services corporate implementation plans including description of service, best practices, roles and responsibilities, key deliverables
- Service level agreements defining specific performance and shared service criteria
- Measure impacts
- Evaluate progress

Year 3 – Deliverables

- Develop a plan to reinvest savings back into the local health care system
- Staff retraining and redeployment plan (focus on core business)
- Expand successes to the wider health care system

Measures

- Increase staff time (in percentage) in provision of direct services
- Increase in overall number of clients served
- Number of staff redeployed to focus on direct service
- Administrative savings to organizations having shared professional services
- Reduction in percentage of time spent on administrative activities
- Number of formal shared service agreements developed

Brief Description of Enabling Projects

Enabling Projects

1. Tri-County CMHA Integration initiatives

Currently, the three Canadian Mental Health associations in the LHIN have grouped together to develop an action strategy (and implementation plan) to realize efficiencies and opportunities for shared services across their organizations, building on each others' successes. From this work, there might be opportunities to expand to include other mental health and smaller addiction service providers that currently do not have the capacity or sufficient funding to support highly specialized administrative services (e.g. human resources, finance, planning, legal services, training, fundraising, etc.).

Initially, LHIN staff will connect with the CMHA group and other groups that might be interested in developing a shared approach to back office and other administrative processes. By acquiring information on their successes and potential integration opportunities, it might be possible to extend existing efforts to other providers that might be interested and able to benefit from this enhanced level of support.

This is an area for early involvement by LHIN staff, as success will lead to the immediate provision of more staff time/resources in the delivery of core client services.

2. e-Chart Development (WRH, WRCC, Hospice, CCAC)

Currently, Windsor Regional Hospital, the Windsor Regional Cancer Centre, the Hospice of Windsor and the Windsor Essex Community Care Access Centre have been using a common patient electronic chart that moves with the patient across their care environment. This initiative has necessitated the development of other support capabilities, such as a common privacy framework and policies and a common patient identifier. Building on the success of these organizations to improve the flow of patient information, there might be an opportunity to initiate a process to generate interest in developing a common vision and action plan that would extend the electronic patient record to the broader health care system.

LHIN staff may help to coordinate and manage this process to expand the initiative and ensure the strategic integration of parallel processes occurring in other health care sectors. There is also a need to broadly communicate the success and opportunity to expand this initiative to the wider health system.

LHIN staff could lead and assist with the development of an e-chart expansion plan (that analyzes information system readiness) and support strategy, linking the appropriate providers to help advance the process.

5. Strategic Integration Direction – System Navigation

Description

The health care system can present a complex and confusing array of services, making it difficult for patients and families to be aware of, and access the appropriate services. There are countless stories of patients who have either "fallen through the cracks" while waiting for treatment, or have had difficulty connecting with the appropriate part of the health care system. System navigation continues to be a concern for many individuals and planning groups.

A central issue to be addressed is whether to have a designated navigator, or to include navigational responsibilities in the roles of all health care providers and patients. Another issue is determining which groups the navigator should work with, and what the associated responsibilities should be (e.g., quality improvement for health professionals, supporting both health professionals and patients, supporting patients to develop self-management skills). Moreover, a navigator may only be needed at certain times (e.g., crisis or acute situations) or in certain cases, such as for those patients lacking reading, language, or Internet skills.

Challenges & Benefits

Stakeholder, including patients, health care professionals, front-line staff, and staff on a health care team, need navigation education. As well, the work flow needs to be redesigned to reduce, or eliminate gaps and areas of overlap and duplication. Another challenge to improved navigation is changing the current roles of some health care professionals.

The main benefits of improved navigation are

- Alleviating the pressures on clients and families to find the right service in the right location in a timely manner

- Enabling people to access the treatment and care they need
- Diagnosing diseases at an earlier stage, when they are less advanced and might lead to better outcomes
- Assisting providers in making more appropriate referrals
- Improving patient follow up
- Improving navigation tools for health care professionals
- Reducing duplication of navigation roles

Current Activities

In Ontario, a number of leading health care organizations have taken positions on the health system navigation issue (e.g. Community Care Access Centres, Cancer Care Ontario, Canadian Mental Health associations). Recommendations put forward vary by location and agency. However, a common element calls for the introduction of changes that would minimize system navigation challenges for individuals seeking to access the system. Some examples of these changes are: centralizing points of access, expanding the case management role, increasing the availability of information for decision-making purposes and providing a focus on sub-populations of vulnerable clients with complex needs. At the same time, there is a need for these organizations to align on a LHIN-wide basis, to discuss how to move forward to enhance coordination and improve navigation efforts across the entire system.

Rationale

The table below was created to indicate part of the magnitude and complexity of the health care system in Erie St. Clair LHIN. The key points are the shortage of some services, the volumes of money spent, the numbers of individuals involved in providing care and the number of very large and very small agencies involved.

Type of Agency	Providers	Organizations	Funding	Programs	Sites	Waiting List	Shortage
Hospitals		5	$435M	many, changing	between 1 and 9	many lists	
LTC facilities			$149M			1,222	
Substance Abuse			$6M			??	
Problem Gambling			$0.8M			??	
Health Disciplines				24			
Pharmacists	437						
Midwifery	8						
GP/FP	373						124
Medical Specialists	356					??	237??
Community Support Services		52	$17M	109	52+	340	
Number of CCACs		3 moving to 1	$80M		dwellings	minimal*	
Children's Treatment Centres		3	$15M		3		

*however, persons are not admitted for care based on CCAC exclusion criteria

Observations

- Definitions of discretion and programs/services vary among agencies
- Staff types and capabilities differ by agency and by program/service. This may be due to collaborative services offered elsewhere in the community, shortages or surpluses of staff, or funding availability/limitations

- There are 24 separate health disciplines covered by provincial legislation. This excludes service providers who deliver care, but who are not covered by Regulated Health Professions Act. Services provided by each discipline are not mutually exclusive and many disciplines can provide the same or related services (or which appear to be the same from the patient's perspective)
- Children's Treatment Centres are usually (although not always in the LHIN), funded by at least two ministries with different target populations. Many other agencies are also funded by more than one ministry of the provincial government
- Raised as a significant concern during community consultations
- Over 100 separate agencies in LHIN are funded by the Ministry of Health and Long-Term Care

LHIN Projects Summary Table

Strategic Projects (1 to 3 years)

1. We will establish a working group to develop a strategic framework for health system navigation

Current Enabling Projects

1. LHIN to assist organizations to identify and/or advance cross-sector positions that would improve navigation (e.g. cancer, hospital in-patient, end of life community providers, end of life care network)

Action Plans for each Project

Project 1: We will establish a working group to develop a strategic framework for health system navigation

Description

Although a number of health care organizations have taken actions aimed at resolving/improving health system navigation at the organizational/sector level, more needs to be done to coordinate and apply these efforts at the broader system level. Despite the existence of formal or informal agreements or practices, individual medical practices in primary care, large multi-site hospitals, municipally operated public health departments/emergency services and community support organizations are all structured and operated primarily as independent entities. Maintaining a system of multiple organizations with separate governing structures encourages development of competing priorities and conflicting strategic directions, which create navigation challenges. In essence, the structure of a health system can either alleviate or contribute to the navigation challenges of its users.

With the establishment of the LHIN and its role in planning for the entire Erie St. Clair region, improved health system navigation has become an increasingly important issue. LHIN staff will lead a system-wide navigation resource group that brings together providers, patients/clients, and other interested stakeholders to discuss their ideas and develop a broader framework from which to build on existing work and promote improved system navigation. The main intent of this project would be to identify enhanced navigation roles and develop formal connections among service providers, so that information sharing and coordination could be shared across the entire LHIN.

Outcomes

- Agreement regarding system navigation roles
- Improved access to health care/service information across all population groups
- Fewer people "falling through the cracks"
- More designated system navigation resources
- More culturally appropriate assistance for navigating the health care system
- Increase awareness of health care treatment options to empower patients and caregivers
- Overall increase in public's education/understanding of health care system

Year 1 – Deliverables

- Development of a strategic framework that will include identification of key issues/gaps/needs regarding system navigation issues
- Develop a report outlining the opportunities to entrance current systems navigation initiatives

Year 2 – Deliverables

- Develop an implementation strategy that identifies actions and resources needed to improved system navigation and sets out timelines
- Advance formal partnership agreements (among provider organizations and professionals) that support improved system navigation and coordinate role determination
- Advance best practice guidelines for system navigation
- Monitor and evaluate the effectiveness of system navigation improvements

Year 3 – Deliverables

- Develop a communications strategy that promotes system- wide navigation for the entire LHIN
- Develop a process for shared accountability that supports system-wide navigation across a variety of service providers
- Ensure that the navigation strategy is aligned with the 10- year Ministry of Health and Long Term Care's strategic plan

Measures

- Percentage of Ontarians effectively navigating the health care system themselves as self reported via a survey
- Number of navigation partnership agreements developed
- Percentage of consumers reporting an increased awareness of the health care system
- Number of new and/or enhanced system navigation positions
- Number of public education events promoting system navigation

Brief Description of Enabling Projects

Enabling Projects

1. LHIN to assist organizations to identify and/or advance across sector positions that would improve navigation e.g. cancer, hospital in patient, end of life community providers, end of life care network.

Currently, a number of organizations have come together to develop shared positions that are jointly funded by multiple organizations and provide coordinated service to the client/patient across the continuum of care. This shared approach has boosted system-wide capacity and allowed for the development of specialized positions that otherwise could not have been justified through a single organization approach to service delivery.

The joint/shared practitioner is able to acquire an in-depth understanding of the services offered by the funding organizations, as well as other community resources available to the client. This unique perspective allows them to work with available resource groups, to ensure that clients/families are navigated to the right resources at the right time.

Because of their improved knowledge of the crossover programs and collaborative involvement with others in the system, shared staff have more specific program information and connections, providing for improved navigation.

LHIN staff is prepared to coordinate a working group (and develop a survey) to identify and review potential opportunities for the collaborative sharing of positions across organizations in order to improve system navigation and increase capacity to serve the wider health care system. This project should help to reduce duplication of staff efforts, thereby freeing up others to provide more direct clinical services.

6. Strategic Integration Direction – Health Human Resources

Description

This strategy focuses on the issue of supply, recruitment, and retention of health care professionals. The health care system is part of a larger sector, often described as the Human Services Industry. As the name implies, human services involves people delivering needed health and/or social services to other people. In particular, the health care system is the largest employer of health care professionals in the human services field. The health care sector is considered to be the largest industry in Canada.

With the tremendous technological advances in diagnosis and treatment has come a rising worldwide demand for skilled health care workers. Health care is increasingly about highly skilled professionals using technology to enhance the care of people in institutions, in health care offices, and in their own homes. Consequently, the LHIN is in the midst of a global competition for skilled professionals, i.e. human capital. Without this human resource, or intellectual capital, the ability to deliver needed programs is seriously compromised. For example, there is little point in having a state-of-the-art operating room, if there are insufficient numbers of nurses, surgeons, and anaesthetists to staff it. Thus, shortages of health professionals have the potential to significantly limit the range and quality of health services provided at the local level.

The prominence of this strategic direction was echoed in a "Feet on the Street" survey of over 7,000 residents in LHIN communities during the summer of 2006. Seventy-five percent of respondents listed "recruitment and retention of family physicians, specialists and other health care providers" as their second highest health care priority (after reducing wait times). While attention is being devoted to this issue, it remains a growing concern to providers, policy makers, and area citizens.

Challenges & Benefits

The challenges facing the LHIN in recruiting and retaining its human resources are similar to those facing many other areas of the province, but, with an additional factor: proximity to a major U.S. medical centre. The challenge also includes:

- Severe shortages of family physicians and specialists, due to a decision made over a decade ago to decrease medical school enrolment and decrease the number of post-graduate training positions (residencies)
- Significant shortages of registered nurses, caused by a variety of factors, but most notably burnout related to workload/stress and limited opportunities for full-time positions
- Shortages of a range of therapists and technologists, due to limitations on the number of spaces funded at universities/colleges
- Since the demographics of the health care workforce mirror those of the general population, it is projected that large numbers of health care professionals will retire over the next five years. It is also projected that

there will be insufficient numbers of trained health care professionals available to fill the void caused by this large-scale retirement

- Concomitant with the large-scale retirement, the numbers of 65+ aged persons will increase significantly. Since there is a direct correlation between age and the amount of health services consumed, demand for health care services will also increase dramatically
- In addition to the above generic challenges, the LHIN, and Windsor-Essex in particular, faces an additional challenge, in the recruitment/retention of health care professionals. Specifically, Windsor is the only Canadian city located immediately adjacent to a large U.S. centre (Detroit). Within the Detroit area, there is a well regarded medical school and several nationally recognized teaching hospitals. Given the shortages of health care professionals in the U.S., there are aggressive (and fairly successful) recruitment campaigns by Michigan hospitals/universities aimed at luring Essex-Windsor health care professionals to work in a Metro Detroit teaching hospital/medical school

The benefits of having an adequate supply of health care professionals include:

- Ability to provide a comprehensive array of health care services at the local level
- Facilitating recruitment of additional health care professionals
- Providing opportunities to develop clinical centres of excellence
- Fostering growth of peer support, continuing education, and research opportunities, which in turn can assist in the retention of health care professionals

Current Activities

The current and projected shortages of health care professionals have been the focus of much study and activity by provincial governments across the country. In Ontario, such efforts include:

- Increasing the numbers of undergraduate spaces funded in existing medical schools
- Streamlining the process for evaluating training/skills of international medical graduates (IMGs) seeking a license to practice in Ontario
- Increasing the number of post-graduate training positions (residencies), including those for family practices
- Providing funding to hospitals to allow them to convert part-time nursing positions to full-time ones
- Extending the scope of practice of a number of health care professions (e.g. extended class RN), to allow them to undertake procedures currently limited to physicians
- Establishment at the University of Windsor of a satellite medical school campus of the University of Western Ontario

At the local level, efforts have focused on the recruitment and retention of health care human resources, and have included:

- Partnering among several organizations to coordinate their recruitment efforts
- Funding provided by some local municipalities, service clubs, and the private sector to hire a full time physician recruiter
- Partnering of organizations to combine funds to enable full time health care providers to be hired
- Local businesses and others preparing incentive packages (e.g. free office space for doctors) to attract the limited number of health care professionals
- Development of alternative models of primary care (e.g. family health teams and community health centres
- Some limited initiatives to deliver continuing education in a user friendly manner, via video conferencing, etc.

Rationale

During the community round table sessions, concerns regarding the shortages and, by extension, limited access to health care professionals, especially family physicians, was consistently raised as a major priority/ concern. This held true for both rural and urban areas, although levels of concern were naturally greater in rural parts of the LHIN.

Specialist Shortage

Specialty	% Short
Geriatric Medicine	-100%
Haematology	-86%
Infectious diseases	-75%
Rheumatology	-75%
Psychiatry	-63%
Nephrology	-63%
Physical Medicine & Rehab	-63%
Cardiology	-60%
Paediatrics	-53%
Gastroenterology	-50%
Thoracic Surgery	-50%
Anatomical Pathology	-46%
Neurology	-46%
Plastic Surgery	-44%
Laboratory Medicine	-43%
Orthopaedic Surgery	-41%
Community/Public Health	-40%
Total Specialists	-40%
Endocrinology	-38%
Anaesthesia	-37%
Respirology	-36%
Dermatology	-33%
Ophthalmology	-33%
Cardiothoracic	-25%
Radiation Oncology	-25%
General Internal Medicine	-23%
Diagnostic Radiology	-22%
Otolaryngology	-17%
Obs/Gynecology	-12%

General practitioner shortage 2006*

Planning Area	Under-Serviced Communities	Shortage	%Short
Chatham-Kent	1	20	29%
Essex	6	76	33%
Lambton	2	28	35%
ESC LHIN	9	124	32%

*Under-Serviced Area Program, MOHLTC, April/May/June 2006

From the above noted tables it has been observed that:

- Overall, the LHIN is 40 per cent undersupplied with specialist physicians compared to the province
- The largest percentages of undersupply are in the specialities of psychiatry, cardiology and paediatrics
- In regard to general practitioners, the LHIN is 32 per cent below its requirement, as calculated by the Under-Serviced Area Program of the MOHLTC

Erie St. Clair LHIN projected service volumes, 2009, 2001, 2016*

Service	2009/10	2011/12	2016/17
Homemaker	6%	10%	23%
Nursing	4%	7%	15%
Dietician	7%	12%	29%
Occupational Therapy	1%	1%	6%
Physiotherapy	7%	11%	29%
Speech Pathology	2%	3%	11%
Social Work	6%	9%	21%
Enterostomal Therapy	6%	105	23%
All Services	6%	9%	22%

*CCAC provided data, August 2006, MOF Population Projections

Community Care Access Centres (CCAC) provide health care services to adults and children in their homes and schools. Data provided by the CCACs was used to project the demand for selected health professions. As shown above, it is projected that the shortages in various professions will worsen, particularly in regards to physiotherapists, enterostomal therapy, dieticians, and speech pathologists.

All Nursing types employed in nursing in Ontario, 2005*

Working Status

	Full-Time	Part-Time	Casual	Combined
ESC LHIN	3,201	2,097	385	5,683
Ontario	67,264	36,683	10,183	114,130
% Ontario	4.8%	5.7%	3.8%	5.0%
% of ESC LHIN Combined	56.3%	36.9%	6.8%	100.0%

*CNO website, Sept 2006

Observations

- The Erie St. Clair LHIN has a higher percentage of nurses working part-time (5.7%) and a smaller percentage of nurses working casual (3.8%) than Ontario. The LHIN has about the same percentage of nurses working full-time as Ontario
- Over half of employed nurses in the Erie St. Clair LHIN are employed full-time
- The Ministry has introduced performance targets indicating that at least 70 per cent of nurses in hospitals should be full time

All Nursing types employed in nursing in Ontario, 2005*

Employment Place

	Institutions	Home/Work	Physician/ Primary Practice	Population Health	Other	Combined
ESC LHIN	3,991	438	316	169	769	5,683
Ontario	83,651	6,821	5,009	3,695	14,954	114,130
% Ontario	4.8%	6.4%	6.3%	4.6%	5.1%	5.0%
% of ESC LHIN Combined	70.5%	7.7%	5.6%	3.0%	13.2%	100.0%

Observations

- Seventy per cent of nurses employed across the LHIN work in institutions, while fewer than eight per cent work in home support, or community workplaces
- Three per cent of nurses work in population (public) health

All nursing types employed in Nursing*

CNO Southwest Ontario Region

Year	Young	MidCareer	Mature	Total
2000	4,533	7,425	1,610	13,568
2001	4,616	7,658	1,812	14,086
2002	4,558	7,921	2,216	14,695
2003	4,518	8,077	2,579	15,174
2004	4,392	7,926	2,760	15,078
2005	4,371	7,748	3,052	15,171

CNO Southwest Ontario Region

Observations

- Data is not available for the Erie St. Clair LHIN prior to 2005, therefore the above table, representing nurses employed in the Southwest Ontario region (which includes Erie St. Clair nurses) is used to illustrate trends
- The total number of nurses employed in the Southwest Ontario region increased between 2000 and 2003, to where it has stabilized at about 15,200 persons
- The number of young nurses (those under 40 years) peaked in 2001 and continues to decline
- The number of mid career nurses (40 to 54 years) rose until 2003 and then began to decline
- The number of mature nurses (those over 55 years) has increased significantly since 2001

Health Human resource Supply ESC LHIN and Ontario

Category	# Members		# Members per 100,000 Population	
	ESC LHIN	Ontario	ESC LHIN	Ontario
Pharmacists	437	10,351	67.6	82.5
Occupational Therapists	138	4,010	21.4	32.0
Physiotherapists	239	6,080	37.0	48.5
Dieticians	85	2,609	13.2	20.8
Midwifery	8	334	1.2	2.7
Medical Laboratory Technologists	N/A	7.738	N/A	61.7
Medical Radiation Technologists	N/A	5,939	N/A	47.4
Speech Language Pathologists	N/A	2.385	N/A	19.0
Registered Nurses	4,252	89,050	657.8	710.1
Registered Nurses - Extended	46	583	7.1	4.7
Registered Practical Nurses	1,385	24,480	214.3	195.2

Source: MOHLTC August 2006

- Although there are limitations in the above data, it is noted that ESC LHIN has fewer health care professionals per 100,000 population than Ontario in all categories, with the exception of Extended Class Registered Nurses and Registered Practical Nurses

LHIN Projects Summary Table

Strategic Projects(1-3 years)

1. We will establish a working group to consider what role we should take regarding Health Human Resources
2. We will establish a mechanism to develop/deliver integrated continuing education programs in the area
3. We will facilitate development and expansion of mentorship programs for health care professionals
4. We will establish a working group to examine how the recruitment training and retention of volunteers can be better integrated and coordinated across the Erie St. Clair LHIN area

Current Enabling Projects

1. Tele Education on palliative care for doctors in the community
2. Erie St. Clair Rehabilitation Network (professional development)

Action Plans for each Project

Project 1: We will establish a working group to consider what role we should take regarding Health Human Resources

Description

The issues of the supply and recruitment/retention of health care professionals has been the focus of a number of provincial initiatives. These efforts notwithstanding, the LHIN heard from numerous groups during the community consultations and in other forums that these issues are a matter of significant concern at the local level. Although many of the solutions to the health human resources issue require provincial intervention, we believe there are opportunities to address some aspects of the problem through innovative, local strategies.

To this end, we will establish a resource group, with representation from the universities of Windsor and Western Ontario, community colleges in the area, physicians, nurses, other health professions and employers.

Outcomes

- Improved local supply of health care professionals
- Stronger position relative to other areas to attract and recruit new health care professionals
- Improved ability to deliver a comprehensive range of health services at local level

Year 1 – Deliverables

- Establish a resource group with representation as described above, to guide the project
- Establish a process to gain consensus and commitment to move this project forward
- Prepare a detailed inventory of existing local initiatives to address the issues of recruitment /retention of health care professionals
- Collect data from local organizations/professional groups on vacancy and turnover rates
- Undertake a literature review to identify best practices and prepare summary
- Organize a think tank with local health care professionals representatives, and external experts
- Identify specific new strategies to be implemented locally to enhance existing activities to address the issue

Year 2 – Deliverables

- Formulate specific action plans for implementation, including measurable outcomes
- Identify specific measures to evaluate outcomes of strategies being implemented

- Establish profession-specific work groups, as needed, to monitor outcomes and assist/advise in resolving implementation problems

Year 3 – Deliverables

- Prepare comprehensive report on project and share with other LHINs, key local stakeholders and general public

Measures

- Retention rates by organization and profession
- Vacancy rates by organization and professions
- Other measures as determined by resource group

Project 2: We will establish a mechanism to develop/deliver integrated continuing education programs in the area

Description

A number of studies have shown that one of the key factors influencing where health care professionals will locate is their ease of access to high-quality, continuing education. In this regard, large urban centres, particularly those located in close proximity to academic health science facilities, have an advantage over less urbanized areas, and/or areas without an academic health science centre nearby. However, based on feedback from local providers and from evidence emerging from the education sector, it appears that modern communications technologies can be used to provide high quality continuing education to health care professionals in their own communities, in the process avoiding the time/cost of attending central locations for such education. A number of projects involving e-health are underway in the province (that have local implications) with the overall goal of harnessing the power and efficiency of information and communications technology to produce better health outcomes for patients.

Outcomes

- Establishment of a formal network of educational and health care organizations to deliver high-quality web based continuing education programs to health care professionals in the LHIN
- Easier access to continuing education programs for health care professionals in small and relatively remote communities, leading to increased participation
- Reduction in costs and lost time for organizations that cover continuing education staff costs
- Support the preparation of a directory of web based education programs for health care workers
- Potential to market locally-produced programs to other LHINs

Year 1 – Deliverables

- Establish work group, including IT expertise to provide oversight for the project

Develop work plan which may include the following :

- A process to gain consensus and commitment to move this project forward
- Prepare inventory of communication/IT currently being used in the LHIN and uses of the technology
- Review literature and identify successful applications of communication/IT modalities to deliver continuing education
- Prepare an environmental scan of emerging technologies that could be used to deliver continuing education programs
- Establish a network to develop and deliver continuing education programs to health professionals closer to home

Year 2 – Deliverables

- Identify mandatory continuing education requirement for those professions where such requirement exist, and survey other health care professionals where minimum requirement do not exist, to identify their educational needs
- Develop potential governance models for establishing/operating the network
- Develop an implementation plan that outlines the steps, resources, timelines needed to succeed
- Implement plan
- Measure impacts
- Evaluate progress
- Continue to assess ongoing needs Year 3 – Deliverables

Year 2 – Deliverables

- Develop new funding models needed to support the long-term implementation of this project

Measures

- Savings in continuing education costs
- Increased participation in continuing education programs
- Improved access to continuing education programs by health care professionals in small communities and/or remote areas

Project 3: We will facilitate the development and expansion of Mentorship Programs for Health Care Professionals

Description

A number of studies have demonstrated that providing mentors to health care professionals when they first join an organization and/or first enter the workforce has a positive influence on both recruitment and retention rates, and also leads to improved quality in service delivery. Locally, there are a number of individual groups working on both formal and informal mentorship programs. This project will seek to build on those initiatives and bring a system-wide perspective to the development of the programs.

Outcomes

- Improved recruitment and retention rates of new health care professionals
- Improved job satisfaction resulting in lower turnover
- Lower training/recruitment costs

Year 1 – Deliverables

- Establish a work group to develop strategic framework for project and to provide oversight
- Identify current mentorship programs, both formal and informal ones, and evaluate
- Review best practices of formal and informal mentoring programs
- Develop and undertake survey of mentorship needs in LHIN

Year 2 – Deliverables

- Develop discussion paper on potential mentorship models, consistent with the strategic framework, and organize workshop to discuss and select models most appropriate for area
- Prepare implementation plan, including timelines, resource requirement and implementation strategies
- Prepare a case study type report, and share with other LHINs, professional associations, and health care organizations

Year 3 – Deliverables

- Evaluate results and develop updated 3-year plan, reflecting lessons learned

Measures

- Numbers of formal and informal mentorship programs established in three years
- Improved job satisfaction
- Decrease in turnover rate for health care professionals

Project 4: We will establish a working group to examine how the recruitment, training and retention of volunteers can be better integrated and coordinated across the Erie St.Clair LHIN area

Description

Volunteers play an important role in the health care delivery system. Virtually every health care organization relies on volunteers to provide a wide array of services, which either compliment services provided by staff or provide a service which would not otherwise be offered. These include governance functions, fundraising, reception/greeters, gift shop and visiting with patients in need of support. In recent years, it has become increasingly challenging for health care organizations to recruit volunteers. A number of societal factors are felt to be responsible for this situation, including volunteer burnout, aging population, fast paced lifestyles with many competing time demands and greater complexity of demands on the volunteer's time.

Outcomes

- More efficient and effective recruitment/training/retention of volunteers
- More efficient use of resources and expertise across organizations resulting in increased productivity and cost savings
- Opportunities for volunteer sharing among organizations
- Increase in number of volunteers

Year 1 – Deliverables

- Survey area organizations to determine issues related to volunteer recruitment, training, and associated costs
- Establish taskforce, to include representation from selected health care organizations representative of total health care sector
- Identify potential opportunities for shared/coordinated service and prepare evaluation of each

Year 2 – Deliverables

- Develop business case for preferred model
- Develop implementation strategy
- Measure impacts
- Evaluate progress

Year 3 – Deliverables

- Measure impacts
- Evaluate progress

Measures

- Reduction in cost of recruitment/training of volunteers
- Improved utilization of volunteer resources
- Increased pool of volunteers
- Increased patient satisfaction

Brief Description of Enabling Projects

Enabling Projects

1. Tele education on palliative care for community doctors.

The Hospice of Windsor currently provides education to family physicians in the area, who wish to provide palliative care to their patients. This program was developed in response to requests from physicians who were being asked by their patients to provide palliative care in the home. Recognizing the heavy demands which already exist on the time of family physicians, an innovative approach, using modern communications technology was developed. The approach enables family physicians to receive the educational program in their offices, or homes.

The initial role for LHIN staff is to meet with the program sponsors in conjunction with the end of life care network and develop a more detailed understanding of the operational details of the program. Next, contact will be made with physician leaders and other groups in the Municipalities of Chatham-Kent and Sarnia Lambton to explore their interest and the potential to implement the program in their area.

This is an area for early involvement by LHIN staff as success will lead to increases in the number of physicians able to respond to requests from patients to provide palliative care either in home or institution.

2. Erie St. Clair Rehabilitation Network.

Currently, rehabilitation professionals in the LHIN are working to establish a rehabilitation network to provide professional development and peer support for members. The initial task for LHIN staff is to meet with the individuals working to establish the network and identify what specific tasks could benefit from the staff's expertise, e.g. facilitation, organizational design, etc.

This is an area for early involvement by LHIN staff, because it offers an opportunity to demonstrate the value of professional development networks in retaining staff. The concept of such networks is strongly supported by the LHIN, and since work is already underway on this project, it has the potential to be fully functional

within a short time period. It might serve as a model and/or encourage other groups to develop their own networks. LHIN staff could also help coordinate and facilitate the process.

7. Strategic Integration Direction – Health Promotion and Illness Prevention

Description

There is a growing consensus on the importance of systematic differences in exposure to health hazards and risk conditions in the population. This means that some groups in society have a much poorer chance of achieving their full health potential as a result of their life circumstances relating to their political, social, economic, and environmental conditions. Further, differences are observed in the health status of groups according to a range of socioeconomic indicators. The most disadvantaged groups have the poorest health and the highest exposure to health damaging risk factors.

There is evidence that poorer socioeconomic groups tend to have poorer nutrition, less physical activity in leisure time, a greater prevalence of smoking and more damaging patterns of alcohol use. However, each factor should not be considered separately. The life circumstances of concern, or determinants of health, include:

- Social and economic circumstances
- Indigenous status
- Ethnicity
- Stress
- Gender
- Early life development and experiences
- Social exclusion
- Work and unemployment
- Social supports

These circumstances can create disadvantages for an individual, who, as a result, could face greater difficulty in making both healthy and easy lifestyle choices.

Further, cultural diversity and the failure of the system to address issues of fair access to appropriate services and programs for diverse groups can create inequalities in health status. Integrated health promotion attempts to close the equity gaps by supporting social networks, developing and advocating healthy public policies, and strengthening community capacity.

Disease or illness prevention focuses on strategies that reduce the risk of disease, identify risk factors, or detect disease in its early, most treatable stages. Examples of disease prevention activities include well baby visits, immunizations, calcium and Vitamin D supplements to reduce the risk of osteoporosis, blood pressure and cholesterol assessments during annual health exams and screening for illnesses such as breast, cervical, colorectal and prostate cancer.

All health care agencies and practitioners have a role in health promotion and illness prevention. Integration strategies that clearly define the various complementary roles and activities are required based on common principles and information. Effective implementation of these roles will reduce the disease and illness burden and contribute to improving health status.

Challenges & Benefits

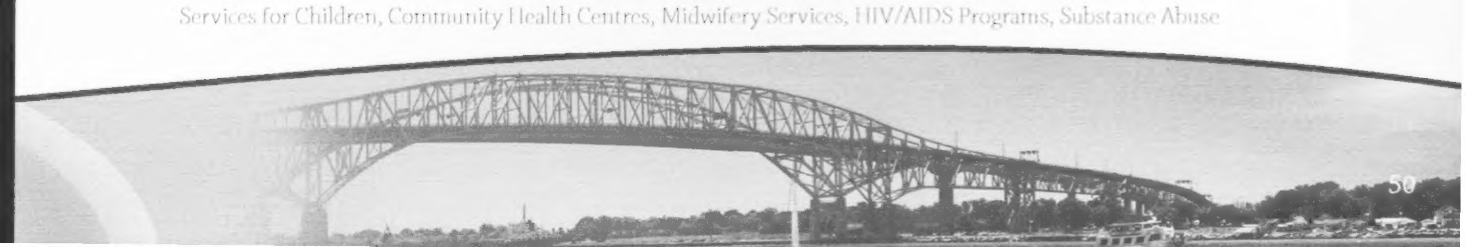
Challenges include increasing awareness and accessibility of health promotion and disease prevention programs, while addressing other broader factors that impact health outcomes. This approach includes addressing existing and emerging infectious diseases, such as West Nile virus, and influenza. Many health problems can be lessened through community wide prevention and early detection programs (e.g., cardiac, stroke, asthma, HIV, smoking cessation, diabetes, etc.). Similarly, chronic diseases can be lessened through public education and skills development, community programming, public policy development, and information that addresses key risk factors.

There is growing evidence worldwide of the benefits and effectiveness of investing in health promotion programs through an integrated approach. Integrated health promotion programs deliver benefits to the community by promoting positive wellbeing, strengthening community capacity, and minimizing the burden of serious diseases, such as diabetes, and cardiovascular disease.

Current Activities

The Ministry of Health Promotion was created to help Ontarians lead healthier lives by delivering programs that promote healthy choices and healthy lifestyles. The Ministry is mandated to work closely with partners, stakeholders and all levels of government. Recognizing the breadth of health promotion, the Ministry will also facilitate access to information and programs through partnerships with the ministries of Health and Long Term Care, Education, Agriculture and Food, Community and Social Services, Children and Youth Services and Labour on initiatives that can target specific sectors of society.

As a core function of the Ministry of Health and Long Term Care, health promotion and disease prevention programs aim to protect, promote, and enhance health, preserve independence, and prevent or delay disease, injury and premature death at all stages of life. Related programs include Health Promotion, Integrated Services for Children, Community Health Centres, Midwifery Services, HIV/AIDS Programs, Substance Abuse



Bureau and Public Health. These programs influence transfer payment accountability, operational policy development, and health promotion and disease prevention planning.

Currently, health promotion and disease prevention play a key role in Ontario's health system. The Ministry of Health and Long Term Care works to develop community based programs in cooperation with public health units across Ontario and a wide range of local partners, such as health service providers, health and community organizations, schools, businesses, and volunteers.

A vital aspect of prevention and early intervention involves working with other ministries in the social services and education sectors, to improve the lives of Ontario's children and youth. Integrated programs such as Healthy Babies, Healthy Children and the preschool speech and language initiatives, are complementary strategies integrate services to better support families.

Rationale

The "Impact" column highlights whether the corresponding percentage reflects a positive (++) impact on area health, or negative ( ).

		Chatham-Kent			
Health Status Attribute		Current	Ratio to Ontario	Change to Meet Ontario	Impact
Self rated health	Fair or poor	8,307	0.82	1,820	++
Self rated mental health	Fair or poor**	4,035	0.90	501	++
Sense of belonging to local community	Very weak	6,309	0.74	2,258	++
Regular medical doctor	Does not have a regular medical doctor**	5,855	0.73	2,261	++
Type of smoker	Current daily or occasional smoker	22,372	1.18	(3,375)	--
Self-reported youth Body Mass Index	Overweight or obese**	1,490	0.90	183	++
Self-reported adult Body Mass Index	Underweight, BMI under 18.50**	1,483	0.67	719	++
Self-reported adult Body Mass Index	Overweight, BMI 25.00 to 29.99	26,687	0.98	550	++
Self-reported adult Body Mass Index	Obese, BMI 30.00 or higher	16,573	1.34	(4,293)	--
Arthritis or rheumatism	With arthritis or rheumatism	17,438	1.11	(1,708)	--
Diabetes	With diabetes	5,716	1.29	(1,284)	--
Asthma	With asthma	9,467	1.29	(2,142)	--
High blood pressure	With high blood pressure	16,410	1.18	(2,409)	--
Injuries within the past 12 months causing limitation of normal activities, 2005*	Injuries	11,736	0.95	660	++
Two-week disability days	1 or more two-week disability days	13,989	0.89	1,716	++
Participation and activity limitation	Participation and activity limitation	28,120	1.04	(1,160)	--
Smoking initiation	5 to 14 years	21,175	1.19	(3,331)	--
Type of smoker	Current daily or occasional smoker	22,372	1.18	(3,375)	--
Exposure to second-hand smoke at home	Exposed to second-hand smoke at home	6,948	1.40	(1,952)	--
Exposure to second-hand smoke in public places	In vehicles**	7,284	1.37	(1,942)	--
Exposure to second-hand smoke in public places	In public places**	4,518	0.51	4,360	++
Frequency of drinking in the past 12 months	5 or more drinks on one occasion, 12 or more times a year	16,628	1.11	(1,710)	--
Leisure-time physical activity	Physically inactive	42,368	1.01	(352)	--
Fruit and vegetable consumption	Less than 5 times per day	53,839	1.10	(4,790)	--
Life stress	Quite a lot	17,581	0.92	1,533	++
Influenza immunization	1 or more years ago	19,091	1.06	(987)	++
Influenza immunization	Never	30,061	0.91	3,114	++
Mammogram within the past two years	No mammogram for at least 2 years	1,659	0.61	1,059	++
Pap smear	Never**	2,777	0.66	1,424	++
Contact with alternative health care providers in the past 12 months	Contact	9,542	0.87	1,500	++
Contact with health professionals about mental health in the past 12 months	Contact**	6,828	1.06	(358)	--
Contact with dental professionals in the past 12 months, 2005*	No contact	34,904	1.26	(7,205)	--

		Essex			
Health Status Attribute		**Current**	**Ratio to Ontario**	**Change to Meet Ontario**	**Impact**
Self Rated Health	Fair or poor	45,361	1.21	(7,795)	--
Self Rated Mental Health	Fair or poor**	14,877	0.90	1,949	++
Sense of Belonging to Local Community	Very weak	30,809	0.97	971	++
Regular Medical Doctor	Does not have a regular medical doctor**	41,676	1.39	(11,570)	--
Type of Smoker	Current daily or occasional smoker	80,091	1.14	(9,622)	--
Self-reported Youth Body Mass Index	Overweight or obese**	6,334	1.01	(70)	--
Self-reported Adult Body Mass Index	Underweight, BMI under 18.50**	6,496	0.78	1,701	++
Self-reported Adult Body Mass Index	Overweight, BMI 25.00 to 29.99	111,544	1.10	(10,157)	--
Self-reported Adult Body Mass Index	Obese, BMI 30.00 or higher	60,402	1.32	(14,690)	--
Arthritis or Rheumatism	With arthritis or rheumatism	70,437	1.21	(12,086)	--
Diabetes	With diabetes	17,837	1.08	(1,396)	--
Asthma	With asthma	25,931	0.95	1,243	++
High Blood Pressure	With high blood pressure	57,028	1.10	(5,092)	--
Injuries within the past 12 months causing limitation of normal activities, 2005*	Injuries	46,535	1.01	(553)	--
Two-week Disability Days	1 or more two-week disability days	62,201	1.07	(3,943)	--
Participation and Activity Limitation	Participation and activity limitation	104,383	1.04	(4,375)	--
Smoking Initiation	5 to 14 years	70,031	1.07	(4,831)	--
Type of Smoker	Current daily or occasional smoker	80,091	1.14	(9,622)	--
Exposure to Second-hand smoke at Home	Exposed to second-hand smoke at home	21,893	1.16	(3,143)	--
Exposure to Second-hand Smoke in Public Places	In vehicles**	23,301	1.17	(3,251)	--
Exposure to Second-hand Smoke in Public Places	In public places**	50,375	1.52	(17,055)	--
Frequency of Drinking in the Last 12 Months	5 or more drinks on one occasion, 12 or more times a year	56,899	1.01	(640)	--
Leisure-time Physical Activity	Physically inactive	159,681	1.02	(3,820)	--
Fruit and Vegetable Consumption	Less than 5 times per day	197,419	1.09	(15,469)	--
Life Stress	Quite a lot	70,181	0.99	647	++
Influenza Immunization	1 or more years ago	72,370	1.08	(5,212)	++
Influenza Immunization	Never	110,588	0.90	12,476	++
Mammogram within the Past Two Years	No mammogram for at least 2 years	9,210	0.78	2,562	++
Pap Smear	Never**	13,270	0.83	2,724	++
Contact with alternative health care providers in the past 12 months	Contact	37,888	0.93	3,072	++
Contact with health professionals about mental health in the past 12 months	Contact**	24,472	1.03	(471)	--
Contact with dental professionals in the past 12 months,2005*	No contact	90,364	0.88	12,388	++

		Lambton			
Health Status Attribute		**Current**	**Ratio to Ontario**	**Change to Meet Ontario**	**Impact**
Self Rated Health	Fair or poor	12,933	1.06	(779)	--
Self Rated Mental Health	Fair or poor**	4,607	0.86	837	++
Sense of Belonging to Local Community	Very weak	4,925	0.48	5,357	++
Regular Medical Doctor	Does not have a regular medical doctor**	6,856	0.70	2,884	++
Type of Smoker	Current daily or occasional smoker	27,079	1.19	(4,280)	--
Self-reported Youth Body Mass Index	Overweight or obese**	1,900	0.91	198	++
Self-reported Adult Body Mass Index	Underweight, BMI under 18.50**	-	-	2,632	++
Self-reported Adult Body Mass Index	Overweight, BMI 25.00 to 29.99	32,804	1.01	(251)	--
Self-reported Adult Body Mass Index	Obese, BMI 30.00 or higher	18,181	1.24	(3,504)	--
Arthritis or Rheumatism	With arthritis or rheumatism	26,790	1.42	(7,912)	--
Diabetes	With diabetes	6,185	1.17	(866)	--
Asthma	With asthma	10,809	1.23	(2,017)	--
High Blood Pressure	With high blood pressure	19,144	1.14	(2,341)	--
Injuries within the past 12 months causing limitation of normal activities, 2005*	Injuries	14,784	0.99	93	++
Two-week Disability Days	1 or more two-week disability days	21,031	1.12	(2,183)	--
Participation and Activity Limitation	Participation and activity limitation	35,945	1.11	(3,589)	--
Smoking Initiation	5 to 14 years	28,845	1.26	(5,994)	--
Type of Smoker	Current daily or occasional smoker	27,079	1.19	(4,280)	--
Exposure to Second-hand smoke at Home	Exposed to second-hand smoke at home	8,546	1.41	(2,493)	--
Exposure to Second-hand Smoke in Public Places	In vehicles**	6,879	1.06	(406)	--
Exposure to Second-hand Smoke in Public Places	In public places**	5,337	0.50	5,420	++
Frequency of Drinking in the Last 12 Months	5 or more drinks on one occasion, 12 or more times a year	23,922	1.27	(5,099)	--
Leisure-time Physical Activity	Physically inactive	47,542	0.94	2,884	++
Fruit and Vegetable Consumption	Less than 5 times per day	65,969	1.12	(7,103)	--
Life Stress	Quite a lot	22,025	0.97	762	++
Influenza Immunization	1 or more years ago	19,325	0.89	2,403	--
Influenza Immunization	Never	41,234	1.04	(1,419)	--
Mammogram within the Past Two Years	No mammogram for at least 2 years	3,248	0.90	340	++
Pap Smear	Never**	3,206	0.63	1,916	++
Contact with alternative health care providers in the past 12 months	Contact	13,650	1.03	(398)	--
Contact with health professionals about mental health in the past 12 months	Contact**	8,935	1.16	(1,170)	--
Contact with dental professionals in the past 12 months,2005*	No contact	29,852	0.90	3,391	++

Compared to Ontario residents:

- more Essex and Lambton residents report poorer health
- more Chatham Kent and Lambton residents reported a somewhat weak sense of belonging to the local community, one of the determinants of health

Lifestyle related:

- more Essex youth and adults reported being overweight or obese
- more Essex adults reported starting smoking earlier (between 5 and 14)
- more Essex residents are current smokers
- more Essex residents are exposed to second hand smoke at home and in vehicles
- more Essex residents drank heavily at least monthly

Diet:

- fewer Essex residents ate five or more servings of fruit and vegetables per day

Use of Health Services:

- substantially more Essex women had a pap smear three or more years prior to the survey
- fewer Essex and Lambton residents contacted a physician in the previous year
- fewer Chatham Kent residents contacted a dentist in the previous year

LHIN Projects Summary Table

Strategic Projects (1 to 3 years)

We will partner with existing networks or establish a working group (including Public Health Units) to develop a broader health promotion strategy for the area which addresses the determinants of health.

Current Enabling Projects

1. Windsor FOCUS Community Teens with addictions (Teen Health Centre)
2. "Call to Action Coalition of Healthy Lifestyle Group" Heart Health
3. Support development of a "community index of wellbeing"

Action Plans for each Project

Project 1: We will partner with existing networks or establish a working group (including Public Health Units) to develop a broader health promotion strategy for the area which addresses the determinants of health

Description

A broader health promotion strategy would focus on population health in the LHIN area creating the conditions that support the best possible health for everyone. This approach recognizes that promoting health is a shared responsibility that requires the coordinated action of many organizations from various sectors working together to improve well being. A key focus of this strategy will be "integrated health promotion" which refers to agencies in a defined area working in a collaborative manner using a mix of health promotion interventions and capacity building strategies to address priority health and well being issuses. The main features of integrated health promotions are:

The development of an effective integrated approach requires effective partnerships. Inter and intra-agency partnership and integration can be presented as a continuum where integration intensifies from networking through to formalized collaborative partnerships. Where collaboration is realized there is leverage of existing agency resources.

A mix of interventions and common planning framework – another key feature is promoting the capacity and commitment to deliver a mix of interventions. The evidence in health promotion practice suggests that to maximize health outcomes a mix of health promotion interventions, encompassing a balance of both individual and population wide health promotion interventions, is required. The interventions need to also be supported by capacity building strategies.

A broad range of sectors – the final feature is the membership of the actual partnership (network). Involvement and integration across a broad range of sectors, including non-government organizations and community groups, is essential, to really address the determinants of health. Other organizations outside the "traditional" primary health sector – such as schools, housing, recreation clubs, and commercial businesses are therefore seen as key partners in the development of the integrated health promotion plan.

Outcomes

- Collaborative health promotion practices among agencies
- Increased public awareness of the benefits of health promotion and support available
- Improved population health
- Improved system-wide population health monitoring, surveillance, and reporting capacity
- In the long term, a decrease in health care costs, as a result of improved health promotion practices

Year 1 – Deliverables

- Partner with existing networks to establish a working group on health promotion and illness prevention with a broad membership (across sectors)
- Develop a common health promotion planning framework (including the determinants of health)
- Advance a common health promotion data collection system and consistent reporting schedule
- Identify/establish health indicators and benchmarks needed to track and assess impacts on population health (including disease prevalence)

Year 2 – Deliverables

- Produce a LHIN-wide integrated health promotion action plan that identifies the appropriate activities to be undertaken by each stakeholder regarding health promotion, infectious disease management, and environmental health
- Assess which areas should be priorities for intervention, based on readiness; develop an implementation strategy for the action plan

- Ensure that there are linkages between the action plan (above) and the Chronic Disease Management Strategic Integration Direction
- Identify the funding needed to support appropriate health promotion activities

Year 3 – Deliverables

- Develop a media campaign for the LHIN, aimed at increasing awareness of the determinants of health
- Monitor and report on ongoing changes to population health in the LHIN

Measures

- Per cent decrease in chronic disease prevalence over time
- More (by per cent) people aware of the determinants of health
- Improved population health
- Dollar savings in acute care resulting from health promotion impacts (system sustainability)
- Per cent of population living longer (increased life expectancy)
- Per cent of people reporting a better quality of life (illness/disability free)
- Per cent decrease in potential years of life lost from chronic illness
- Per cent of LHIN residents over 75 years of age living in the community

Brief Description of Enabling Projects

Enabling Projects

1. Windsor FOCUS Community Teens with Addictions:

Alcohol and other substance abuse is a serious problem that takes its toll on individuals, families, and society as a whole. The estimated cost to Ontario of alcohol and substance abuse is $9.2 billion per year in health care, law enforcement, and lost labour productivity. Alcohol use alone accounts for about one half of these costs. It is estimated that 10 per cent of all deaths in Ontario result, directly or indirectly, from alcohol consumption.

The Ministry of Health and Long Term Care has developed a five year, $12 million FOCUS Community Program to prevent alcohol and other drug abuse in 21 communities across Ontario that have demonstrated a commitment to addressing this issue. Children and youth are key audiences, with each project being asked to allocate at least one third of its budget to reaching young people.

The FOCUS Community Program builds on the success of a demonstration project to prevent alcohol and substance abuse at sites in 11 communities. An evaluation found that the demonstration project provided a promising model for preventing alcohol and other substance abuse. Based on these findings, as well as

national and international research, the ministry has developed an additional five-year provincial FOCUS Community Program for implementation at the 11 existing sites, as well as at 10 new ones.

1. Windsor Focus Community Teens with Addictions (Teen Health Centre)
The LHIN staff could become involved with this project in Windsor (led by the Teen Health Centre) to assess its overall impact and determine if it should be extended across the LHIN.

2. Call to Action Coalition of Healthy Lifestyle Group - Heart Health
The Heart Health Program, a $17-million, five year investment in preventing cardiovascular disease, is delivered through public health units and their local partners across the province. It is the largest program of its kind ever undertaken in North America, and makes Ontario the leading jurisdiction for heart health programming. The program's goal is to raise public awareness of the three key lifestyle factors linked to a reduced risk of cardiovascular disease and cancer (avoiding tobacco use, eating a healthy, low-fat diet and staying active throughout life).

The Ministry of Health and Long Term Care provides funding for the Heart Health Resource Centre at the Ontario Public Health Association. The centre provides consultation, training and resources to Heart Health programs across Ontario. It also houses the Heart Health Network, a provincial network of health professionals working in the field of cardiovascular disease prevention.

Our involvement with this area would help to increase awareness of the importance of healthy lifestyles, and by being involved with the group LHIN staff could review its progress and identify gaps, barriers and needs. It would also be important to link this area with the chronic disease management strategy creating/promoting a community partnership that seeks to reduce the incidence of chronic diseases through healthy lifestyle choices.

3. Support development of a "Community Index of Wellbeing"
The Canadian Index of Wellbeing (CIW) supported by the National United Way, seeks to provide Canadians with a clear, valid, and regular accounting of the things that matter to them and the genuine progress of Canada. The CIW is being developed as a tool to account honestly and accurately for changes in the human, social, economic, and natural wealth through a new index that can best capture the full range of factors that determine wellbeing in Canada. The index will be used to help foster a common vision for the future of Canada, one that can be used as a basis for improving health and well being outcomes that matter to Canadians.

The CIW, now under construction, uses powerful indicators that count and measure the extent to which Canadians are realizing their values and goals as a society and whether they are leaving the world a better place for the children. Based on measures that are clear, valid, and regularly reported, the new index will round out our understanding of Canada's economic reality and longer-term prosperity by integrating it with information on the social, health, and environmental conditions that shape our communities.

Through the CIW, a common vision for the future of Canada will emerge, one that can be used as a basis for improving the health and wellbeing outcomes that matter to Canadians. This tool will provide policy shapers and decision-makers with the information they need to measure the full benefits and costs of policy changes.

Our involvement with this project would be twofold. First, to become more educated about the CIW and how it can be refined and applied in the health care environment, it would be necessary to assess and measure the impact of change. Secondly, we could also help to ensure the success of the CIW, through its involvement in strategic partnerships that promote efforts to engage public and stakeholder input in this visionary work. It will take a growing base of community partners to keep this work meaningful and sustainable and a real commitment to anchor this work at the grassroots level, by ensuring that Canadians from all walks of life are engaged in the process.

8. Strategic Integration Direction - Timely Access to Appropriate Care and Service

Description

Timely access to quality health services is a fundamental principle for the establishment and sustainability of an effective and efficient health care system. Services need to be available when people need them. Currently, access issues have emerged as a result of a shortage of primary care, excessive wait times for specialty care, a lack of transportation to and from non-urgent care, availability of some diagnostic testing and screening services and a need for improved health system flow-through processes. Strategies are required to identify and, where possible, eliminate/manage access issues that contribute to ineffective or inefficient patient care.

Studies show that countries with strong primary care systems have healthier populations and are better able to use their scarce health care resources more efficiently. Access to primary care can be a function of capacity as well as delivery models, and is particularly problematic for some groups with special needs, such as those suffering from mental illness. Primary Health Care Renewal in Ontario encompasses improved access to primary health care services that help weave the various parts of the health system together. The implementation of family health teams is a key transformation strategy, through which the government will provide more Ontarians with access to primary health care.

Reducing wait times for key health services is one of the Ontario government's top priorities and an important part of its strategy for transforming the province's health system. Wait times are a symptom of the broader

problem of managing how patients get access to care. The Wait Time Strategy's key objective is to reduce the time that adult Ontarians wait for cancer surgery, cardiac revascularization procedures (cardiac surgery, percuataneous coronary intervention, diagnostic catherization), cataract surgery, hip and knee total joint replacements, and MRI/CT scans, by improving access to those services. A patient trying to access the appropriate services can experience delays at many different points along the way (e.g. general practitioner referral to a specialist, tests or screening, specialist referral for surgery). Waiting for a health care service is not necessarily a bad thing, but, it becomes a cause for concern, if the waiting extends beyond a clinically appropriate time and/or starts to impact upon a person's health, social and economic wellbeing.

Stakeholders have experienced difficulty transferring non emergency patients between health care facilities in a timely and efficient manner. Transfers can be delayed, or rescheduled due to redirected ambulance priorities and the lack of available transportation alternatives. These circumstances generally result in delayed treatment, leading to inefficient use of scarce resources as procedures must be cancelled and rescheduled to a different date. Consumers and patients sometimes experience problems accessing appropriate transportation, in order to receive medical or health services. Although an array of transportation services is available to the public, sometimes people don't know they exist, or know how to access them. In other instances transportation services simply do not exist, particularly in rural areas.

Challenges and Benefits

Timely access to appropriate care can reduce the severity of the problem and the intensity of required care. Primary health care includes, but is not limited to: disease management and prevention, disease cure, rehabilitation, palliative care and health promotion. Many people in Ontario, and in the Erie St. Clair LHIN in particular, do not have regular access to primary care services provided either by a general practitioner or nurse practitioner. As a result, people might wait to access care, or choose to not access care. Such a situation might, in turn, lead to delayed treatment, increased complications, and place undue strain on other services, particularly hospital emergency departments.

Timely access to specialty services is also a problem. Although the public and providers are concerned about wait times prior to the launch of the Ministry's Wait Time Strategy, no one knew precisely how long the majority of people waited for most procedures.

Individual physicians manage their own wait lists and decide how urgently a patient needs surgery. Hospitals use the information to allocate blocks of times to surgeons, or related services, schedule the surgeries, and make sure operating rooms are appropriately staffed and equipped. How long a patient waits depends predominantly on the attending surgeon, the resources a hospital has available and whether emergencies occur. Moreover, the length of time a patient waits can be influenced by a number of other factors. For example, patients with illnesses not considered life threatening may wait longer when emergency cases arise. Long waits for certain physicians may also occur if they receive more referrals due to practice patterns. In addition, patients and referring physicians might not be aware of specialists with shorter waiting lists because the information is not routinely collected and shared within the medical community.

Previous studies have identified that considerable savings and increased capacity in the health care system can be achieved by developing alternative means to more efficiently transfer patients between health care facilities in a timely and coordinated manner. Also, the public needs to be better informed about available transportation services to and from health services. Where transportation does not exist, creative solutions must be found to fill the gap in service.

Current Activities

The Ministry of Health and Long Term Care has initiated primary care reform and the Wait Time Strategy to improve access to primary care, cancer surgery, cardiac revascularization procedures (cardiac surgery, percutaneous coronary intervention, and diagnostic catherization), cataract surgery, and hip and knee total joint replacements, and MRI/CT scans. Local initiatives are underway to address these needs and to improve access to other services. A number of family health teams have been approved for the LHIN in order to expand access to primary care services and promote a team approach to care provision. Patient transfers between facilities are increasingly being contracted to the private sector which specializes in non-urgent patient transfers. In addition, many agencies and services provide volunteer transportation services for those in need.

Rationale

Comparable waiting times are extremely difficult to generate. Providers in some sectors have made significant advances over the recent past to gather and disseminate useful information. The tables below have varying degrees of stability, but they are the best currently available information and form a basis from which to start the discussions.

With federal level support, provinces now collect very useful information on waiting times for selected conditions and procedures. The data are collected at the institutional level, and so do not necessarily reflect the waiting times for persons by community. For procedures not performed in Erie St Clair LHIN (e.g. Angioplasty, Coronary Artery Bypass Surgery), the waiting times shown are those for the Southwest LHIN – the service site for the majority of Erie St. Clair LHIN residents for these procedures.

Wait times for selected procedures*

			Target	Aug-Sep05	Oct-Nov05	Dec05-Jan06	Feb-Mar06	Apr-May06
Cancer Surgery	Median	Ontario		24	21	23	22	23
		ESC LHIN		15	15	18	19	19
	90%	Ontario	84	81	73	76	78	77
		ESC LHIN		52	49	57	57	71
Angiography	Median	Ontario		15	14	14	13	13
		ESC LHIN		27	22	19	11	22
	90%	Ontario		56	39	39	33	31
		ESC LHIN		58	35	52	16	39
Angioplasty**	Median	Ontario		5	5	5	4	4
		SW LHIN		4	4	4	3	5
	90%	Ontario		28	25	26	21	20
		SW LHIN		41	34	39	26	26
Bypass Surgery**	Median	Ontario		14	13	14	13	16
		ESC LHIN		22	19	16	21	27
	90%	Ontario	182	49	42	45	41	48
		ESC LHIN		54	50	50	49	50
Cataract Surgery	Median	Ontario		99	93	78	78	76
		ESC LHIN		36	25	31	30	37
	90%	Ontario	182	311	314	297	291	277
		ESC LHIN		160	185	93	128	124
Total Hip Replacement	Median	Ontario		119	106	96	97	99
		ESC LHIN		125	110	103	99	113
	90%	Ontario	182	351	341	331	336	329
		ESC LHIN		234	231	211	211	245
Total Knee Replacement	Median	Ontario		147	150	122	123	146
		ESC LHIN		112	127	118	143	161
	90%	Ontario	182	440	431	422	395	408
		ESC LHIN		288	351	307	386	422
MRI	Median	Ontario		32	27	32	28	31
		ESC LHIN		8	23	31	41	43
	90%	Ontario	28	120	110	105	88	91
		ESC LHIN		26	96	71	61	78
CT	Median	Ontario		13	14	14	13	13
		ESC LHIN		7	25	27	8	14
	90%	Ontario	28	81	79	74	69	71
		ESC LHIN		112	102	84	85	97

*MOHLTC website, Aug 2006

**these procedures are not provided within ESC LHIN, Data for Southwest LHIN are provided

Wait time for selected procedures*

ESC LHIN as Percent of Ontario's result

		Aug-Sep05	Oct-Nov05	Dec05-Jan06	Feb-Mar06	Apr-May06
Cancer Surgery	Median	63%	71%	78%	86%	83%
	90%	64%	67%	75%	73%	92%
Angiography	Median	180%	157%	136%	85%	169%
	90%	104%	90%	133%	48%	126%
Angioplasty**	Median	80%	80%	80%	75%	125%
	90%	146%	136%	150%	124%	130%
Bypass Surgery**	Median	157%	146%	114%	162%	169%
	90%	110%	119%	111%	120%	104%
Cataract Surgery	Median	36%	27%	40%	38%	49%
	90%	51%	59%	31%	44%	45%
Total Hip Replacement	Median	105%	104%	107%	102%	114%
	90%	67%	68%	64%	63%	74%
Total Knee Replacement	Median	76%	85%	97%	116%	110%
	90%	65%	81%	73%	98%	103%
MRI	Median	25%	85%	97%	146%	139%
	90%	22%	87%	68%	69%	86%
CT	Median	54%	179%	193%	62%	108%
	90%	138%	129%	114%	123%	137%

*MOHLTC website, Aug 2006

Observations

- In general, cancer surgery and cataract surgery waiting times are lower in Erie St. Clair LHIN facilities than in Ontario overall
- Angioplasty, bypass surgery, total hip replacement and CT scanning waiting times are higher in Erie St. Clair LHIN facilities than in Ontario overall

Radiation therapy median time from referral to treatment*

March to May 2006

				Ratio to Ontario Average of Medians	
Cancer Type	London Regional Cancer Centre	Windsor Regional Cancer Centre	Unweighted Average of Medians	London Regional Cancer Centre	Windsor Regional Cancer Centre
Breast	8.0	6.0	6.5	1.23	0.92
Central Nervous System	**	2.7	3.9		0.70
Gastro-Intestinal	2.9	**	3.5	0.82	
Genitourinary Cancers	7.7	13.4	7.7	1.00	1.75
Gynecologic	6.9	3.5	6.8	1.01	0.51
Haematology	1.1	3.7	4.9	0.22	0.75
Head and Neck	4.5	2.3	5.1	0.89	0.45
Lung	2.1	3.9	2.6	0.80	1.49
Sarcoma	5.7	**	6.7	0.85	

*Cancer Care Ontario website, Aug 2006

Systemic therapy median time from referral to treatment*

March to May 2006

				Ratio to Ontario Average of Medians	
Cancer Type	London Regional Cancer Centre	Windsor Regional Cancer Centre	Unweighted Average of Medians	London Regional Cancer Centre	Windsor Regional Cancer Centre
Breast	5.5	3.8	4.7	1.17	0.81
Central Nervous System	**	**	4.2		
Gastro-Intestinal	5.7	3.7	5.2	1.09	
Genitourinary Cancers	4.9	1.6	4.7	1.04	0.34
Gynecologic	5.6	1.9	4.4	1.27	0.43
Haematology	3.8	4.1	4.4	0.87	0.94
Head and Neck	2.7	**	4.1	0.66	
Lung	4.0	4.3	4.4	0.91	0.98
Sarcoma	3.8	**	6.0	0.63	

*Cancer Care Ontario website, Aug 2006

Observations

- Radiation therapy waiting times for genitourinary and lung cancer are longer than Ontario
- Systemic therapy waiting times for all types of cancer are shorter than Ontario

There are two types of waiting times reviewed for Community Care Access Centres – waiting related to Long Term Care placement and waiting for professional services.

CCAC long term care placement volumes, 2005/06*

Planning Area	New Referral - LTC	Admission to LTC Placement	File Closed - Admitted to LTC Home	Interim LTC Placement-Not 1st Choice	Days to be Accepted by LTC Facility	Days Waited for LTC Placement	Avg. Days Waited for LTC Placement	Bed-Equivalents at 99%
Chatham-Kent	447	445	280	65	2,893	27,726	62	77
Essex	1,379	1,322	370	619	0	170,537	129	472
Lambton	555	553	301	227	7,255	61,094	110	169
ESC LHIN	2,381	2,320	951	911	10,148	259,357	112	718
Ontario	50,604	43,846	19,120	13,912	146,705	5,996,057	137	16,593

*MOHLTCFIM website

CCAC average waiting times for service initiation, 2005/06

Planning Area	Nursing	Shift Nursing	Nutritionist	Physiotherapy	Occupational Therapy	Speech/ Language Pathology	Social Work	Homemaking	School Support	Respite
Chatham-Kent	1.6	0.7	12.2	8.0	13.5	13.1	14.6	1.6	9.8	2.4
Essex	1.7	-	4.7	3.5	10.3	9.3	7.9	1.6	-	-
Lambton	1.1	0.7	5.7	5.5	17.9	82.4	5.0	3.4	-	2.5
ESC LHIN	1.5	0.7	6.4	4.8	12.0	19.6	8.6	2.1	9.8	2.4
Ontario	1.5	2.3	10.1	9.8	19.0	34.2	11.9	3.2	2.4	13.0

Ratioed to Ontario average wait times

Planning Area	Nursing	Shift Nursing	Nutritionist	Physiotherapy	Occupational Therapy	Speech/ Language Pathology	Social Work	Homemaking	School Support	Respite
Chatham-Kent	1.10	0.31	1.21	0.82	0.71	0.38	1.23	0.50	4.14	0.18
Essex	1.13	-	0.47	0.35	0.54	0.27	0.67	0.50	-	-
Lambton	0.76	0.30	0.57	0.56	0.95	2.41	0.42	1.05	-	0.19
ESC LHIN	1.04	0.30	0.63	0.49	0.64	0.57	0.72	0.65	4.14	0.19
Ontario	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00

*MOHLTCFIM website

Observations

- Of the 2,320 persons who were admitted to the CCAC Long Term Care placement program, 911 were placed in a facility that was not their first choice. This can lead to replacement, family and resident distress and increased administrative burdens on providers
- If all the waiting days were converted to bed-equivalents at 99% (almost full at all times), an additional 718 beds would be required in Erie St. Clair LHIN
- The longest average waiting time to service initiation was for speech language/pathology (almost 20 days). The average waiting times for the highest volume services were 2.1 days (homemaking/personal support) and 1.5 days (nursing)
- Waiting times to service initiation for all services except school support compare favourably to very favourably with Ontario times

Children's treatment centres, 2005/06*

Planning Area	Physiotherapy	Occupational Therapy	Speech Language /Pathology	Audiology	Social Work
Chatham-Kent	70	246	201	48	127
Essex	12	70	27	0	4
Lambton	57	517	269	281	128
ESC LHIN	42	294	181	131	53
Ontario	175	263	244	91	200

Ratios to Ontario wait times

Planning Area	Physiotherapy	Occupational Therapy	Speech Language /Pathology	Audiology	Social Work
Chatham-Kent	0.40	0.94	0.82	0.52	0.63
Essex	0.07	0.27	0.11	-	0.02
Lambton	0.32	1.97	1.10	3.09	0.64
ESC LHIN	0.24	1.12	0.74	1.44	0.26
Ontario	1.00	1.00	1.00	1.00	1.00
Ontario Average	175	263	244	91	200

*Based on 2005/06 YE MIS trial balance submissions from CTCs, funds 2+3

Observations

- Reported waiting times for all services at Children's Treatment Centres except for occupational therapy, speech language/pathology and audiology are lower than Ontario overall
- Essex does not report having audiology services

Reported waiting lists for community support services 2005/06*

Service	C-K	Essex	Lambton	ESC LHIN	as % of ESC clients
Homemaking/Personal Supp/Attendant/Respite-Phys Dis Outreach	4	5	12	21	9%
Transportation	-	5	-	5	0%
Security Checks/Reassurance Service	1	2	-	3	1%
Supportive Living Service - Physically Disabled Adults	16	18	18	52	55%
Homemaking/Personal Supp/Attendant - Elderly in SHU	6	-	-	6	21%
Friendly Visiting	45	41	34	120	35%
Adult Day Service-Integrated-Frail/Alzheimers/Other Dementia	-	1	-	1	0%
Home Maintenance and Repair (Brokerage)	-	-	7	7	2%
Special Services For the Blind and Visually Impaired	-	45	-	45	3%
Special Services For Persons with Acquired Hearing Loss	-	2	-	2	0%
Supportive Living Service - ABI in SHU	-	3	-	3	43%
Geriatric Assessment Program - Windsor	-	75	-	75	20%
Combined	72	197	71	340	1%

*from "Summary Report on Community Support Services" MOHLTC FIM

Observations

- Twelve of the 30 service types (provided by 52 agencies) in Erie St. Clair LHIN reported waiting lists at year end 2005/6
- Although the waiting list totals for Supportive Living totaled 55 persons over 1/3 of those on the waiting list were waiting for Friendly Visiting

LHIN Projects Summary Table

Strategic Projects (1 to 3 years)

1. We will establish a working group to identify priority issues and develope strategic plan to improve access, particularly in rural areas
2. We will identify gaps and implement strategies to improve primary care access and service
3. We will identify priority transportation issues and implementable solutions

Current Enabling Projects

1. Community Care Access Centre Chatham-Kent Association and Canadienne Française French Language Service Project
2. Dual Diagnosis Program
3. Erie St. Clair Rehabilitation Network

Action Plans for each Project

Project 1: We will establish a working group to identify priority issues and develop strategic plan to improve access, particularly in rural areas

Description

Identifying and eliminating access issues and reducing waiting times for services are critical to sustaining and effective health care system. The Ministry of Health and Long Term Care has identified wait times for some key services as a priority across the province. A working group would be established to identify key issues and appropriate strategies, to improve access and reduce wait times for services across the LHIN, with a particular emphasis on rural issues.

Outcomes

- Earlier diagnosis and treatment for patients
- Identification of problems, gaps, and needs for the rural population

- Measurable reduction in wait times for services
- Reduced patient anxiety
- Measurable increase in patient satisfaction
- Improved clinical outcomes for patients

Year 1 – Deliverables

- Establish and support an expert group to lead the process
- Review literature and current/best practices to identify appropriate models and processes
- Review data and conduct an environmental scan to identify issues
- Develop a process for prioritizing issues
- Consult with providers and consumers to obtain feedback on priorities and solutions
- Conduct research if necessary

Year 2 – Deliverables

- Initiate planning to develop action plans and an implementation strategy for first two or three priorities
- Establish action groups for each initiative and priority
- Develop practice guidelines, as required

Year 3 – Deliverables

- Continue to support Year 2 implementation projects and initiate action on two or three additional priorities
- Repeat Year 2 actions for new priorities

Measures

- Reduced wait times for to access specialty services
- More timely and effective treatment
- Improved health status
- Reduced patient anxiety

Project 2: We will establish a working group to identify gaps and implement strategies to improve primary care access and service

Description

Primary care services are the main access point into the health care system. If access is poor, patients do not receive timely services, which can result in increased severity and ultimately increased costs. The Ministry of Health and Long Term Care has initiated reform for primary care by creating new models of service and implementing various incentives to attract practitioners. We have a role in improving primary care services.

Outcomes

- Increased capacity for primary care services
- Improved consumer satisfaction
- Improved access to other health services for patients
- Timely access to primary care, diagnosis and treatment for patients
- Improved health promotion and prevention activities
- Health care practitioners are better informed of options for patients

Year 1 – Deliverables

- Establish a working group to lead the project
- Develop and conduct a LHIN workshop on primary care to educate and update service providers on options and models, and to identify issues and solutions
- Establish a local network to support family health teams, community health centers and other primary care groups
- Establish a primary care strategy for the LHIN, including an environmental scan, a community engagement process and an implementation plan

Year 2 – Deliverables

- Implement initial phase of primary care strategy
- Continue to support network

Year 3 – Deliverables

- Continue to update and support implementation of primary care strategy

Measures

- Growth in number of new primary care models (e.g. family health teams)
- Reduced number of orphaned/unattached patients
- Improved recruitment and retention of primary care practitioners
- Reduced inappropriate utilization of emergency departments

Project 3: We will establish a working group to identify priority transportation issues and achievable solutions

Description

Transportation is a long standing and complex issue that is particularly problematic in rural areas. Various transportation services exist, but there are gaps in service. As well, the public is not fully aware of available transportation options and how to access them. Non-emergency transfers between health care agencies in the LHIN and outside the LHIN might experience delays, resulting in system inefficiencies. The project will focus on issue identification and solution development.

Outcomes

- Improved access to services
- Improved coordination of transportation services
- More efficient use of limited resources
- Increased public understanding of available services
- Increased public use of available transportation options

Year 1 – Deliverables

- Establish a working group to lead the project
- Conduct environmental scan to develop an inventory of services and an analysis of data
- Identify priority issues and corresponding practical strategies

Year 2 – Deliverables

- Implement strategies identified by expert group
- Continue to monitor and evaluate transportation issues

Year 3 – Deliverables

- Continue to monitor and evaluate transportation issues

Measures

- Reduced number of rescheduled transfers
- Reduced wait time for transfers between facilities
- Fewer delayed, or cancelled procedures
- Increased capacity of some services (i.e. CT)

Brief Description of Enabling Projects

Enabling Projects

1. Community Care Access Centre, Chatham-Kent & Association Canadienne Française French Language Services Project

This federally funded accord, supported by several agencies in Chatham-Kent, provides health promotion and service information in French for the local Francophone community. The group would benefit from LHIN support for the overall strategy and assistance in identifying ways and means to make the service accessible to the entire LHIN.

2. Dual Diagnosis

Service agreement is being developed between CMHA and Windsor Regional Hospital to share a position to better serve those with dual diagnosis. Other partnerships can be explored to enhance services for this group.

DECISION CRITERIA

APPENDIX H

ERIE ST. CLAIR LHIN DECISION CRITERIA

APPENDIX H

As the Erie St. Clair LHIN assembled and organized information and advice from a variety of sources, it was important to develop clear criteria in which to assess potential objectives and directions. Using the Cancer Care Ontario priority setting criteria as a basis, the Erie St. Clair LHIN modified the criteria to better align with the LHIN Integrated Health Services Plan process.

Below is the criteria used by various LHIN committees in order to assess potential strategic directions and associated actions.

Erie St. Clair LHIN Priority Setting Criteria

1. Criteria - Strategic Fit/ Alignment with External Directives

Context Question

- Do the activities/recommendations advance strategic directions and/or the key principles/guidelines for future health service delivery?
- Elimination of barriers to access
- Commitment to service equity and diversity
- Better integration/coordination strategies
- Effective and efficient use of health care services
- Sustainable Services

2. Criteria – Alignment with Academic Mandates

Context Question

- Do activities play a role in the education of future health care professionals in establishing best practice standards, in generating new health knowledge and in developing technological innovation?

3. Criteria - Clinical Impact of Recommendation

Context Questions

- Do activities address the critical mass needed to ensure clinical competence?
- Are activities evidence based?
- Do activities address continuum of care and contribute to improved continuity of care?

4. Criteria - Community Needs Assessment

Context Question

- Do suggested activities address the health service needs of the population in the catchment area (as identified by demand, by utilization rates, by waiting list, population health and epidemiological data)?

5. Criteria – Building on Partnerships (External)

Context Question

- Do suggested activities build on existing relationships and reflect the existing formal agreements and commitments with other organizations in coordinating delivery of health care services?

6. Criteria – Building on Interdependency (Internal)

Context Question

- Do suggested activities address coordination and collaboration between services to enhance service quality and efficient use of resources?

7. Criteria - Resource Implications

Context Questions

- Do suggested activities address the recruitment, retention and/or effective use of human and fiscal resources?
- Are the suggested activities feasible within existing financial and human resources(early wins)?

CANCER PLANS

APPENDIX I

EMERGING CANCER PLANS

APPENDIX I

Regional Cancer Plans

Over the next three months, a group of leaders and providers from the health care system will develop a regional cancer plan for the Erie St. Clair LHIN. This plan will span the continuum of care from prevention to palliative care and end of life, highlighting priorities for improvement and action from 2007//08-2009/10. It will be essential to align this plan with the IHSP for the ESC LHIN and the Ontario Cancer Plan.

As the regional cancer plan is created, it will be recognized that cancer is a chronic disease where earlier diagnosis and improved treatment lead to better outcomes and increased survival overall. Many individuals now live 20 years or more managing a diagnosis of cancer. Given that cancer is linked to ageing, we can expect a growing incidence of cancer in line with an ageing population for the LHIN and population growth in Essex County. Other important risk factor analysis, surveillance, and service utilization data will be considered in shaping the priorities for change.

Within the Erie St. Clair LHIN, two regional cancer centres serve its residents Windsor Regional Cancer Centre and London Regional Cancer Program (LRCP). Many of the residents of the Sarnia-Lambton area use LRCP as do a significant portion of the residents of Chatham-Kent. The regional cancer plan for the ESC LHIN must identify strategies for collaboration and partnership with providers and organizations from the Southwest LHIN, including the Regional Cancer Services Alliance and LRCP. Such inter-LHIN collaboration will maximize opportunities for innovation and improvement that will benefit the cancer systems in both regions resulting in the best possible care being available to residents from both LHINs regardless where they live.

During the Erie St. Clair regional cancer planning process, care will be taken to ensure the action goals set along the cancer continuum will reflect the clinical priorities identified by Cancer Care Ontario. For example, development of a colorectal cancer screening program, increased participation in breast and cervical screening, Diagnostic Assessment Unit standards, multidisciplinary cancer conferences, clinical practice guidelines, strategies to decrease wait times to cancer treatment and collaborative palliative care planning.

The target date for the Windsor Regional Cancer Center completion of the regional cancer plan is December 2006. Attached to this appendix is the London Regional Cancer Centre preliminary plan.

RCSA
Regional Cancer Services Alliance

Revised

SOUTHWEST REGIONAL

CANCER PLAN

As reviewed and approved by the
RCSA Executive on
July 25, 2006

September, 2006

Acknowledgements

We acknowledge the efforts required by many to complete the revisions to the Southwest Regional Cancer plan in a timely, comprehensive, and quality fashion. Specifically, we wish to note the Regional Cancer Planning Team members, Kevin Churchill, Sue Nugent, Mike Barrett, Gale Turnbull, Ingrid Harle, and members of the Regional Cancer Services Alliance (RCSA) Executive, Pat Campbell, Sandra Coleman, Nancy Maltby-Webster, who joined the team to guide the work. Thanks goes also to the cancer service networks and work teams who provided content for the revised plan.

In particular, we would like to thank Brenda Carter for initiating this effort and Manuella Giuliano who worked with each team to develop planning templates, performance indicators, and work plans.

Finally we wish to thank Harry Milne for completing the final phases of the planning work and for writing the report.

Betty Kuchta & Nancy Maltby-Webster
Co-Chairs, Regional Cancer Services Alliance, Executive

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Executive Summary

In March 2004, stakeholders and partner organizations in cancer care began this most recent phase of cancer service planning for Southwestern Ontario. The aim of the Southwest Regional Cancer Plan was to:

- Critically review the entire continuum of cancer services currently being provided,
- Identify opportunities to improve the system,
- Commit to realistic performance measures to monitor improvements,
- Set a 3-year work plan to improve cancer system performance in the region.

Regional Developments

Since completion of the regional cancer plan in 2004, several significant changes regarding the organization of health care and cancer care in particular have occurred. Some of these changes include:

- Local Health Integration Networks charged with the responsibility to improve integration and coordination of all health care in each Ontario region.
- Reviews of Community Care Access Centres (CCACs) and Public Health Units (PHUs) to determine how care is best organized and delivered within a regional context continue with the announcement of CCAC re-organization to align with LHIN structures anticipated imminently.
- Cancer Care Ontario continues to develop as a provincial cancer care/ service quality monitoring organization, placing accountability for the coordination and integration of cancer services across the continuum on the 14 regional cancer programs.
- In February 2006 and in response to CCO call for improved coordinated cancer service, Thirty-four provider and service organizations in the Southwest and Erie St Clair LHINs, signed an agreement holding each other accountable for the improvement of care and service within their part of the cancer system.

From January to March 2006 and with the help of an experienced community planner, leaders from each of the cancer service sectors engaged in a review and re-fresh of the 2004 southwest regional cancer plan. Planning leaders represented prevention and early detection, radiation therapy, systemic therapy, disease site teams, surgical oncology, supportive care and palliative care. Erie St. Clair and South West Local Health Integration Network Senior Planning Directors were asked to take part and provide input to the plan revisions.

Based on an analysis of the information collected, a number of strategic directions, performance indicators, and work plans were identified for the SW Regional Cancer Services Alliance. Recommended strategic directions are provided below, with the entire revised plan presented Chapter 3 of this report.

SUMMARY OF RCSA STRATEGIC ACTIVITIES 2005-2008

ELEMENTS OF THE REGIONAL CANCER PLAN	STRATEGIC ACTIVITIES
PREVENTION AND EARLY DETECTION	• To implement Phase II of the OBSP unattached woman's program targeting women 50-69 years in Southwest who don't have a family physician. • To develop and implement a cervical screening health promotion project targeting all women in the South and Southwest regions of Ontario to raise awareness regarding issues of access to cervical screening. • To implement a project targeting youth to reduce ultraviolet exposure using regional and local activities that address Cancer 2020 targets for sun/UV.
SYSTEMIC THERAPY	• To provide education opportunities through Videocare for all community chemotherapy clinic staff in the region and cancer patients. • To explore the feasibility of clinical trials in community chemotherapy clinics within the LRCP region. • To maximize the delivery of safe & effective chemotherapy services in existing community chemotherapy clinics.
RADIATION TREATMENT	• To identify, develop and implement process improvement strategies through the Cancer Services Improvement Program (CSIP) for all areas of the radiation treatment program to improve access to radiation therapy services. • To identify and develop strategies to increase the rate of referrals to the LRCP radiation treatment program.
DISEASE SITE TEAMS	• To develop and implement integrated and coordinated regional cancer guidelines/care pathways.
SURGICAL ONCOLOGY	• To facilitate the development of communities of practice within LRCP region to support the sharing of knowledge and evidence-based practice to improve the quality of cancer surgery. • To support dissemination and use of clinical guidelines to facilitate evidence-based practice.
SUPPORTIVE CARE	• To continue to support and grow the Oncology Care Coordination (OCC) Program within the RCSA region. • To collaborate with End of Life and Palliative Care to implement common assessment tools, Edmonton Symptom Assessment Scale (ESAS) and Palliative Performance Scale (PPS) within the RCSA region. • To coordinate a SW Supportive Care in Oncology Conference for Spring 2007.
PALLIATIVE CARE	• To establish a platform, in collaboration with End of Life Networks in LHIN 1 & 2, to facilitate the integration of palliative care physicians within the Southwest Regional Palliative Care Program. • To implement a disease site based physician palliative care model at LRCP: identify palliative care physician champions within the RCSA region. • To develop and implement clinical practice strategies to ensure quality palliative care service delivery. • To develop and implement education strategies to meet the needs of oncology patients and their families and cancer care professionals. • To collaborate with CCO's Palliative Care committee in developing a mechanism to accurately capture and report palliative care data.

1.0 Introduction

In March 2006, stakeholders and partner organizations in cancer care began this most recent phase of cancer service planning for Southwestern Ontario. Building from the previous Regional Cancer Plan (2004) and following the recent signing of the Regional Cancer Services Alliance (February, 2006), planners focused on validating the previous plan ensuring that strategic activities were aligned with Cancer Care Ontario's (CCO) strategic directions, measurable, and represented improvements from across the continuum of cancer care and service. The aim, 2004 Regional Plan status, description of the planning process, and key elements of the revised plan are described in this chapter.

1.1 Aim

The aim of the Southwest Regional Cancer Plan was to bring together partners and stakeholders and with to:
- Review the entire continuum of cancer services currently being provided,
- Identify strategic activities that would improve the system,
- Commit to realistic performance measures to monitor improvements,
- Set a 3-year work plan to improve cancer system performance in the region.

The review included:
- Southwest Regional Cancer Plan 2004,
- Southwest community consultations completed in 2005,
- Cancer Care Ontario (CCO) strategic directions (Ontario Cancer Plan, 2004) and Cancer Service Quality Indicators (CSQI)
- Southwest Regional Cancer Services Alliance – Accountability Agreement (February, 2006)
- Priority-setting framework based on the Ethical Framework: "Accountability for Reasonableness" (AFR) to the selected strategic initiatives.

1.2 2004 Regional Plan Status Update

In the 2004 Southwest Regional Cancer Plan, a number of initiatives were identified.

The initiatives that have been completed include:
- Regional and local accountability for the delivery of cancer services in Southwest Ontario.
- Oncology care coordination for patients and families.

Cancer plan initiatives that are in progress include:
- A coordinated system for palliative care in Southwestern Ontario.

No further work has occurred on the following 2004 plan initiatives:
- Implementation of comprehensive clinical pathways for breast and lung cancer
- Wait times from suspicion of cancer to definitive surgical treatment

Description of the Process

From January to March 2006 and with the help of an experienced community planner, leaders from each of the cancer service sectors engaged in a review and re-fresh of the 2004 Southwest Regional Cancer Plan. Planning leaders represented prevention and early detection, radiation therapy, systemic therapy, disease site teams, surgical oncology, supportive care and palliative care. Erie St. Clair and South West Local Health Integration Network Senior Planning Directors were asked to take part and provide input to the plan revisions.

Using the "logic model' framework (Appendix A), leaders requested input and confirmed the content of the revised plan with members of already existing regional networks and work teams.

Finally, priority setting for the identified strategic initiatives was determined by applying the Ethical Framework: "Accountability for Reasonableness" (Appendix B). In August 2006, the strategic directions were reviewed and approved by the Southwest Regional Cancer Services Alliance Executive.

1.3 Key Elements of the Revised Southwest Regional Plan 2006

Strategic activities from across the cancer continuum are presented in the following table. A complete description of the activities that includes performance indicators and work plans are presented in Chapter 3 of this report.

SUMMARY OF RCSA STRATEGIC ACTIVITIES 2005-2008

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PALLIATIVE CARE	• To establish a platform, in collaboration with End of Life Networks in LHIN 1 & 2, to facilitate the integration of palliative care physicians within the Southwest Regional Palliative Care Program. • To implement a disease site based physician palliative care model at LRCP: identify palliative care physician champions within the RCSA region. • To develop and implement clinical practice strategies to ensure quality palliative care service delivery. • To develop and implement education strategies to meet the needs of oncology patients and their families and cancer care professionals. • To collaborate with CCO's Palliative Care committee in developing a mechanism to accurately capture and report palliative care data.

2.0 Regional Changes Since 2004 Plan

Since completion of the regional cancer plan in 2004, several significant changes regarding the organization of health care and cancer care in particular have occurred. Some of these changes include:

- Local Health Integration Networks charged with the responsibility to improve integration and coordination of all health care in each Ontario region.
- Reviews of Community Care Access Centres (CCACs) and Public Health Units (PHUs) to determine how care is best organized and delivered within a regional context. The CCAC will be reorganized into 14 CCACs across Ontario. The new structures wil lbe aligned with the LHIN boundaries.
- Cancer Care Ontario continues to develop as a provincial cancer care/service quality monitoring organization, placing accountability for the coordination and integration of cancer services across the continuum on the 14 regional cancer programs.
- In February 2006, and in response to CCO's call for improved coordinated cancer service, 34 provider and service organizations in the Southwest and Erie St Clair LHINs, signed an agreement holding each other accountable for the improvement of care and service within their part of the cancer system.

Opportunities continue to exist to work closely with the Windsor Regional Cancer Centre (WRCC) on the west side and Grand River Regional Cancer Centre (GRRCC) on the east. Work with WRCC has started to build care closer to home capacity within Chatham Kent, leveraging local interest and capability to the extent possible and to coordinate appropriate distribution of referrals between WRCC and LRCP for optimized access to specialized services such as radiation therapy treatments. Both LRCP and GRRCC have agreed to work closely together to build each centre's profile and credentials over this time through disease site team development and close collaboration on strategic initiatives where appropriate to ensure smooth redefinition of referral patterns in the future as patient access dictates.

2.1 Map of the RCSA Region

3.0 Strategic Directions, Performance Indicators, Work plans

2006-2008 STRATEGIC INITIATIVES

3.1 PREVENTION AND EARLY DETECTION

Strategic Activities

- To implement Phase II of the OBSP unattached woman's program targeting women 50-69 years in Southwest who don't have a family physician.
- To develop and implement a cervical screening health promotion project targeting all women in the South and Southwest regions of Ontario to raise awareness regarding issues of access to cervical screening.
- To implement a project targeting youth to reduce ultraviolet exposure using regional and local activities that address Cancer 2020 targets for sun/UV.

Performance Indicators

Goal:
- Increase by 10 % the number of women, without a family physician, participating in organized screening

CCO Indicator:
- % of screen-eligible women participating in organized screening

Regional Indicator:
- % of women, without a family physician, participating in organized screening by county

Goal:
- **Increase by 5% the overall number of eligible women participating in organized screening.**

Regional Indicator:
- % of screen-eligible women participating in organized screening

Work Plan

➔ Indicates work currently conducted within resource availability.
⇨ Indicates achievements if additional resources were available.

STRATEGIC ACTIVITY	CURRENT STATUS	EXPECTED IMPLEMENTATION OF STRATEGIC ACTIVITY							
		YEAR 1(06-07)				YEAR 2 (07-08)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ACTIVITY 1- To implement Phase II of the OBSP Unattached Woman's program targeting women 50-69 years in Southwest who don't have a family physician.	Project is ready for implementation.			➔	➔				

STRATEGIC ACTIVITY	CURRENT STATUS	EXPECTED IMPLEMENTATION OF STRATEGIC ACTIVITY							
		YEAR 1(06-07)				YEAR 2 (07-08)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. Campaign strategies/activities implemented by local Health Units addressing media, community, workplace and healthcare facilities.									
ACTIVITY 2 – To develop and implement a cervical screening health promotion project targeting all women in the South and Southwest regions of Ontario to raise awareness regarding issues of access to cervical screening.	Southwest Public Health Units have developed a plan to implement the cervical screening health promotion project ad will be meeting to finalize the project's goals and objectives.								
1. Strategies developed and implemented				→					
2. Barriers to access identified						→			
3. Report /qualitative research on barriers from women's perspective developed				→		→			
4. Collaborative partnerships established					→		→	→	→
	Partnerships for the cervical screening health promotion project include Public Health Units, Canadian Cancer Society, Ontario Cervical Screening Program and Cancer Care Ontario.				→	→			
5. Encourage participation by all health units in the Rapid Risk Factor Surveillance Surveys.									
6. Encourage Health Units participating in the Rapid Risk Survey to select the survey component on cervical screening	There are ongoing negotiations at the Ministry of Health and Long-term care regarding funding to support the use of Rapid Risk Factor Surveillance Surveys by all health units.								
ACTIVITY 3 – To implement a project targeting youth to reduce ultraviolet exposure using regional									

STRATEGIC ACTIVITY	CURRENT STATUS	EXPECTED IMPLEMENTATION OF STRATEGIC ACTIVITY							
		YEAR 1(06-07)				YEAR 2 (07-08)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
and local activities that address Cancer 2020 targets for Sun/UV exposure.									
1. Support and endorse any local/provincial/federal policy development regarding tanning beds	At the provincial level, all health units have participated in the development of a position paper supporting the development and implementation of a provincial policy regarding tanning beds. The Prevention and Early Detection Network will identify how to support the provincial initiative.		→						
2. Collaborate with the South West Skin Cancer Prevention Network to distribute "Overexposed" to teen audiences within the region and to explore peer led health promotion strategies	"Overexposed", a magazine for teens about artificial and solar tanning, has been disseminated region wide. The South West Skin Cancer Prevention Network will lead the exploration of peer led health promotion strategies, which will be supported by the Prevention and Early Detection Network.		→	→	→				

3.2 SYSTEMIC THERAPY

Strategic Activities

- To provide education opportunities through Videocare for all community chemotherapy clinic staff in the region and cancer patients.
- To explore the feasibility of clinical trials in community chemotherapy clinics within the LRCP region.

- To maximize the delivery of safe & effective chemotherapy services in existing community chemotherapy clinics.

Performance Indicators

Goal:
Improved access to cancer services locally

CCO Indicator:
- Proportion of clinics applying provincial standards of practice
- % of stage 2 breast and lung cancer patients treated with adjuvant systemic therapy according to clinical practice guidelines
- % of stage 3 colon and rectal cancer patients receiving adjuvant systemic therapy according to clinical practice guidelines
- Median wait times from ready to treat to start of systemic therapy within community chemotherapy clinics
- % of cancer patients treated at cancer centres recruited to treatment-based clinical trials

Regional Indicator:
- Proportion of cancer patients within each county of the region receiving chemotherapy in existing regional community chemotherapy clinics

Workplan

➔ Indicates work currently conducted within resource availability.
⇨ **Indicates achievements if additional resources were available.**

STRATEGIC ACTIVITY	CURRENT STATUS	EXPECTED IMPLEMENTATION OF STRATEGIC ACTIVITY							
		YEAR 1 (06-07)				YEAR 2 (07-08)			
		Q 1	Q 2	Q 3	Q4	Q 1	Q 2	Q 3	Q 4
ACTIVITY 1 - To provide education opportunities through Videocare for all community chemotherapy clinic staff in the region and cancer patients. OUTPUTS 1. Training sessions offered to all cancer care professionals involved in community chemotherapy clinics	Will be working with LRCP education to identify strategies to facilitate collection of education inventory and education modalities for community chemotherapy clinics.		➔	➔	➔				
2. Ongoing cancer patient education provided to patients throughout their treatment regimen	See above								
3. Inventory of the types of education/training	See above								

STRATEGIC ACTIVITY	CURRENT STATUS	EXPECTED IMPLEMENTATION OF STRATEGIC ACTIVITY							
		YEAR 1 (06-07)				YEAR 2 (07-08)			
		Q 1	Q 2	Q 3	Q4	Q 1	Q 2	Q 3	Q 4
provided for systemic therapy community chemotherapy clinics.									
ACTIVITY 2 – To explore the feasibility of clinical trials in community chemotherapy clinics within the LRCP region. OUTPUTS 1. Identify criteria for conducting clinical trials within community chemotherapy clinics.	Subcommittee will be struck to identify needs of community chemotherapy clinic with respect to information about clinical trials and potential for participation in phase 2 & 3 trials according to criteria.			→	→				
2. Identified community chemotherapy clinics able to conduct clinical trials	Once the subcommittee has identified their needs and eligibility criteria, activities 2 and 3 can be implemented in year 2.					→	→	→	→
3. Identification of patents eligible for clinical trials within the community chemotherapy clinics.						→	→	→	→
ACTIVITY 3 – To maximize the delivery of safe and effective chemotherapy services within existing community chemotherapy clinics. OUTPUT 1. Development of an alert system to redirect patients to community chemotherapy clinics	All the community chemotherapy clinics have agreed to discuss the development of a standard template to capture information about alert systems as well as costs related to drug wastage, supply costs and current human resources capacity and implementation of activities 2, 3 and 4 will occur in year 2.			→	→				
2. Development of a compliance system for consistent safe practice within community chemotherapy clinics in						→	→	→	→

STRATEGIC ACTIVITY	CURRENT STATUS	EXPECTED IMPLEMENTATION OF STRATEGIC ACTIVITY							
		YEAR 1 (06-07)				YEAR 2 (07-08)			
		Q 1	Q 2	Q 3	Q4	Q 1	Q 2	Q 3	Q 4
SW									
3. Identification of a financial accountability system for drug acquisition, wastage costs, resource utilization and supply costs.						➔	➔	➔	➔
4. Development of an evaluation process to identify the use of supportive care drugs as related to chemotherapy administration and other indicators.						➔	➔	➔	➔

3.3 RADIATION TREATMENT

Strategic Activities

- To identify, develop and implement process improvement strategies through the Cancer Services Improvement Program (CSIP) for all areas of the radiation treatment program to improve access to radiation therapy services.
- To identify and develop strategies to increase the rate of referrals to the LRCP radiation treatment program.

Performance Indicators

Goal:
- To improve access to radiation therapy services

CCO Indicator:
- Median waits from referral to start of radiation treatment
- Median and 90th percentile waits in weeks from referral to start of radiation for breast, genitourinary

Regional Indicator:
- Proportion of cancer cases receiving radiation within year of diagnosis by county

Workplan

➔ Indicates work currently conducted within resource availability.
⇨ Indicates achievements if additional resources were available.

STRATEGIC ACTIVITY	CURRENT STATUS	EXPECTED IMPLEMENTATION OF STRATEGIC ACTIVITY							
		YEAR 1 (06-07)				YEAR 2 (07-08)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Activity 1 - To identify, develop and implement process improvement strategies through the Cancer Services Improvement Program (CSIP) for all areas of the radiation treatment program to improve access to radiation therapy services.	Awaiting findings of the CSIP process regarding priorities.	➔					➔		➔
1. CSIP process mapping; data collection			➔						
2. Result of CSIP process.			➔						
3. Implementation of priorities				➔	➔	➔		➔	
Activity 2 - To identify and develop strategies to increase the rate of referrals to the LRCP radiation treatment program.			➔				➔		➔
1. Establish a committee to address the rate of referrals with representatives from the continuum of cancer care in the LRCP region.				➔	➔ ➔				
2. Recommendations articulated identifying strategies to address rate of referrals.						➔	⇨	➔	⇨
3. Implement strategies proposed.						⇨		⇨	

3.4 DISEASE SITE TEAMS

Strategic Activities

1) To develop and implement integrated and coordinated regional cancer guidelines/care pathways.

Performance Indicators

Goal:

- To develop and implement integrated and coordinated cancer care pathways

Regional Indicator:

- Proportion of patients registered on regional pathway to total patients eligible.

Workplan

➔ Indicates work currently conducted within resource availability.
⇨ Indicates achievements if additional resources were available.

STRATEGIC ACTIVITY	1.1 CURRENT STATUS	EXPECTED IMPLEMENTATION OF STRATEGIC ACTIVITY							
		YEAR 1 (06-07)				YEAR 2 (07-08)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CLINICAL Activities: 1. To develop and implement integrated and coordinated cancer care pathways ▪ Cancer care pathways in place addressing the continuum of cancer care.	Process to disseminate and monitor regional care guidelines currently not in place. Additional resources would be required to develop and implement this initiative.			⇨	⇨	⇨	⇨	⇨	⇨

3.5 SURGICAL ONCOLOGY

Strategic Activities

1) To facilitate the development of communities of practice within LRCP region to support the sharing of knowledge and evidence-based practice to improve the quality of cancer surgery.
2) To support dissemination and use of clinical guidelines to facilitate evidence-based practice.

Performance Indicators

Goal:

- To support dissemination and use of clinical guidelines to facilitate evidence-based practice.

Regional Indicator:

- Proportion of patients on surgical guidelines to total number of patients eligible for guidelines.

Workplan

➔ Indicates work currently conducted within resource availability.
⇨ Indicates achievements if additional resources were available.

STRATEGIC ACTIVITY	CURRENT STATUS	EXPECTED IMPLEMENTATION OF STRATEGIC ACTIVITY							
		YEAR 1 (06-07)				YEAR 2 (07-08)			
		Q1	Q2	Q3	Q4	Q 1	Q2	Q3	Q4
ACTIVITY 1- To facilitate the development of communities of practice within LRCP region to support the sharing of knowledge and evidence-based practice to improve the quality of cancer surgery	Work has started to identify London-based surgical leaders.			⇒	⇒	⇒	⇒	⇒	⇒
ACTIVITY 2 – To support dissemination and use of clinical guidelines to facilitate evidence-based practice.	Not started					⇒	⇒	⇒	⇒

4.6 SUPPORTIVE CARE

Strategic Activities:

1) To continue to support and grow the Oncology Care Coordination (OCC) Program within the RCSA region.
2) To collaborate with End of Life and Palliative Care to implement common assessment tools, Edmonton Symptom Assessment Scale (ESAS) and Palliative Performance Scale (PPS) within the RCSA region.
3) To coordinate a SW Supportive Care in Oncology Conference for Spring 2007.

Performance Indicators:

Goal:
To continue to support and grow the Oncology Care Coordination (OCC) Program

Regional Indicator:

- # of individuals referred to CCAC's for Oncology Care Coordinators (Baseline data available from the pilot phase to act as comparator. Also compared to # people diagnosed with cancer for corresponding period.

Goal:

- To implement common assessment tools, Edmonton Symptom Assessment Scale (ESAS) and Palliative Performance Scale (PPS).

Regional Indicator:

- # of Community Care Access Centres, hospitals, long-term care facilities and hospices utilizing ESAS and PPS (# orgs implemented/total # orgs).

Workplan:

➔ Indicates work currently conducted within resource availability.
⇨ Indicates achievements if additional resources were available.

STRATEGIC ACTIVITY	CURRENT STATUS	EXPECTED IMPLEMENTATION OF STRATEGIC ACTIVITY							
		YEAR 1				YEAR 2			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
To continue to support and grow the Oncology Care Coordination (OCC) Program within the LRCP region.	OCC is available in each county for all people living with cancer throughout the full illness continuum.	➔	➔	➔ Data Pull	➔	➔ Data Pull	➔	➔ Data Pull	➔
To collaborate with End-of-Life Care Networks and Palliative Care to implement common assessment tools, Edmonton Symptom Assessment Scale (ESAS) and Palliative Performance Scale (PPS) within the LRCP region.	In progress, SW EOLC Network and local networks are working on implementation. Team is being assembled at LRCP to determine how best to implement at LRCP. Work plan to be developed and presented to SW EOLC Network in September.			➔	➔	➔	➔	➔	➔
To coordinate a SW Supportive Care in Oncology Conference for Spring 2007.	Conference Planning Team identified.	➔	➔	➔	➔	Conference to be held			

3.7 PALLIATIVE CARE

Strategic Activities:

1) To establish a platform, in collaboration with End of Life Networks in LHIN 1 & 2, to facilitate the integration of palliative care physicians within the Southwest Regional Palliative Care Program.
2) To implement a disease site based physician palliative care model at LRCP: identify palliative care physician champions within the RCSA region.
3) To develop and implement clinical practice strategies to ensure quality palliative care service delivery.
4) To develop and implement education strategies to meet the needs of oncology patients and their families and cancer care professionals.
5) To collaborate with CCO's Palliative Care Committee in developing a mechanism to accurately capture and report palliative care data.

Performance Indicators:

Goal:

- To implement clinical practice strategies to ensure quality palliative care service delivery.

CCO Indicator:

- Proportion of palliative care providers in receipt of standards and guidelines
- Proportion of palliative care patients dying in setting of choice (hospital, home, other)
- Rate of emergency room visits locally and regionally by patients deemed palliative.
- Rate of physician visits in clinics and in the home for palliative care services

Regional Indicator:

- Proportion of patients referred to palliative care compared to the total diagnosed with cancer (as identified by palliative treatment flag – LRCP).
- % of providers utilizing ESAS and PPS.

Workplan:

➔ Indicates work currently conducted within resource availability.
⇨ Indicates achievements if additional resources were available.

STRATEGIC ACTIVITY	CURRENT STATUS	EXPECTED IMPLEMENTATION OF STRATEGIC ACTIVITY							
		YEAR 1 (06-07)				YEAR 2 (07-08)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ACTIVITY 1- To establish a platform, in collaboration with End of Life Networks in LHIN 1 & 2, to facilitate the integration of palliative care physicians within the Southwest Regional Palliative Care Program. 1. Program administrative support acquired. 2. Recruitment of partners and key stakeholders 3. Regular meetings conducted	Meetings with LHIN #2 stakeholders, End of Life Network, CCACs and Pain and Symptom Groups initiated by Dr. Ingrid Harle regarding palliative care program and disease site based physician model. (Elgin, Huron Perth, Oxford, Norfolk, Grey Bruce)	➔	➔	⇨	⇨	⇨	⇨	⇨	⇨

STRATEGIC ACTIVITY	CURRENT STATUS	EXPECTED IMPLEMENTATION OF STRATEGIC ACTIVITY							
		YEAR 1 (06-07)				YEAR 2 (07-08)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Activity 2 - To implement a disease site based physician palliative care model at LRCP: identify palliative care physician champions within the RCSA region. 1. Model established to deliver regional palliative care services 2. Business case developed to secure funding for the model 3. Physicians identified locally and within the region interested in participating in the model 4. Training provided for physicians re the regional palliative care model.	Meetings with LHIN #2 stakeholders, End of Life Network, CCACs and Pain and Symptom Groups initiated by Dr. Ingrid Harle regarding palliative care program and disease site based physician model to identify potential physician champions. (Elgin, Huron Perth, Oxford, Norfolk, Grey Bruce)	➔	➔	⇨	⇨	⇨	⇨	⇨	⇨
5. Partnerships developed within the region with the Southwest Supportive Care Network, End of Life Network and Local Cancer Services Networks.		➔							
	Dr. Ingrid Harle member of LHIN 2 End of Life Network and local End of Life Network through London Middlesex CCAC; CCO Palliative Care Program Committee; RCSA.		➔						
	Dr. Ingrid Harle has presented the palliative care disease site based physician model to the supportive care program at LRCP including social workers, nurse practitioners and neurologists.		➔						

STRATEGIC ACTIVITY	CURRENT STATUS	EXPECTED IMPLEMENTATION OF STRATEGIC ACTIVITY							
		YEAR 1 (06-07)				YEAR 2 (07-08)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Dr. Ingrid Harle has provided training to LRCP GPOs via videoconference and county physicians were invited to attend the weekly education sessions.								
Activity 3 - To develop and implement clinical practice strategies to ensure quality palliative care service delivery. 1. Dissemination of palliative care common assessment tools (ESAS and PPS) to appropriate palliative care service providers 2. Development and dissemination of CCO palliative care guidelines and standards for all palliative care service providers 3. Training provided for use of common assessment tools and guidelines and standards 4. Usage of common assessment tools and palliative care standards and guidelines 5. Development of consistent documentation standards 6. Development of an effective referral process	Dr. Ingrid Harle has provided training regarding PPS and ESAS to London Middlesex CCAC with invitations to Elgin and Huron Perth. LHSC, Parkwood and LRCP will receive training with invitation to regional stakeholders to participate via videoconference. CCACs, End of Life Network and Pain and Symptom management are scheduled to implement a referral process by 2007.		➔	⇨	⇨	⇨	⇨	⇨	⇨
Activity 4 - To develop and implement education strategies to meet the needs of oncology patients and their families and cancer care professionals. 1. Patient education resources identified, developed, if needed, and disseminated 2. Education strategies for cancer care professionals developed and implemented				⇨	⇨	⇨	⇨	⇨	⇨

STRATEGIC ACTIVITY	CURRENT STATUS	EXPECTED IMPLEMENTATION OF STRATEGIC ACTIVITY							
		YEAR 1 (06-07)				YEAR 2 (07-08)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Activity 5 - To collaborate with CCO's Palliative Care committee in developing a mechanism to accurately capture and report palliative care data. 1. Participation in CCO Palliative Care Committee meetings 2. Dissemination of information from CCO Palliative Care Committee to local and regional stakeholders 3. Identification of barriers within the region to collecting consistent data 4. Identification of strategies to improve data collection and analysis in the region 5. Dissemination of new knowledge re palliative care throughout the region to palliative care providers				⇨	⇨	⇨	⇨	⇨	⇨

4.0 Conclusions

As first reported in the 2004 Southwest Cancer Plan, the burden of illness from cancer in Southwestern Ontario over the next 10 years can expected to be higher than other regions in the province given the age profile in the region, the expected growth within that older population and the associated impact on the prevalence of cancer.

In Southwestern Ontario there is a higher proportion of 50+ individuals living in the region when compared to the provincial average. The growth in the population is expected to result in a higher incidence and mortality due to cancer over the next 10 years compared to the averages for Ontario overall. The data reveals that Southwest population rates are less than the provincial averages for consuming a healthy diet and adequately controlling weight. Additionally, the percentage of smokers or those who have smoked is higher in the region than the province and a higher rate (42%) of non-smokers are exposed to second-hand smoke in their homes. Particularly alarming is the increase in smoking rates for teenage women. Clearly, work to prevent cancer needs to be enhanced.

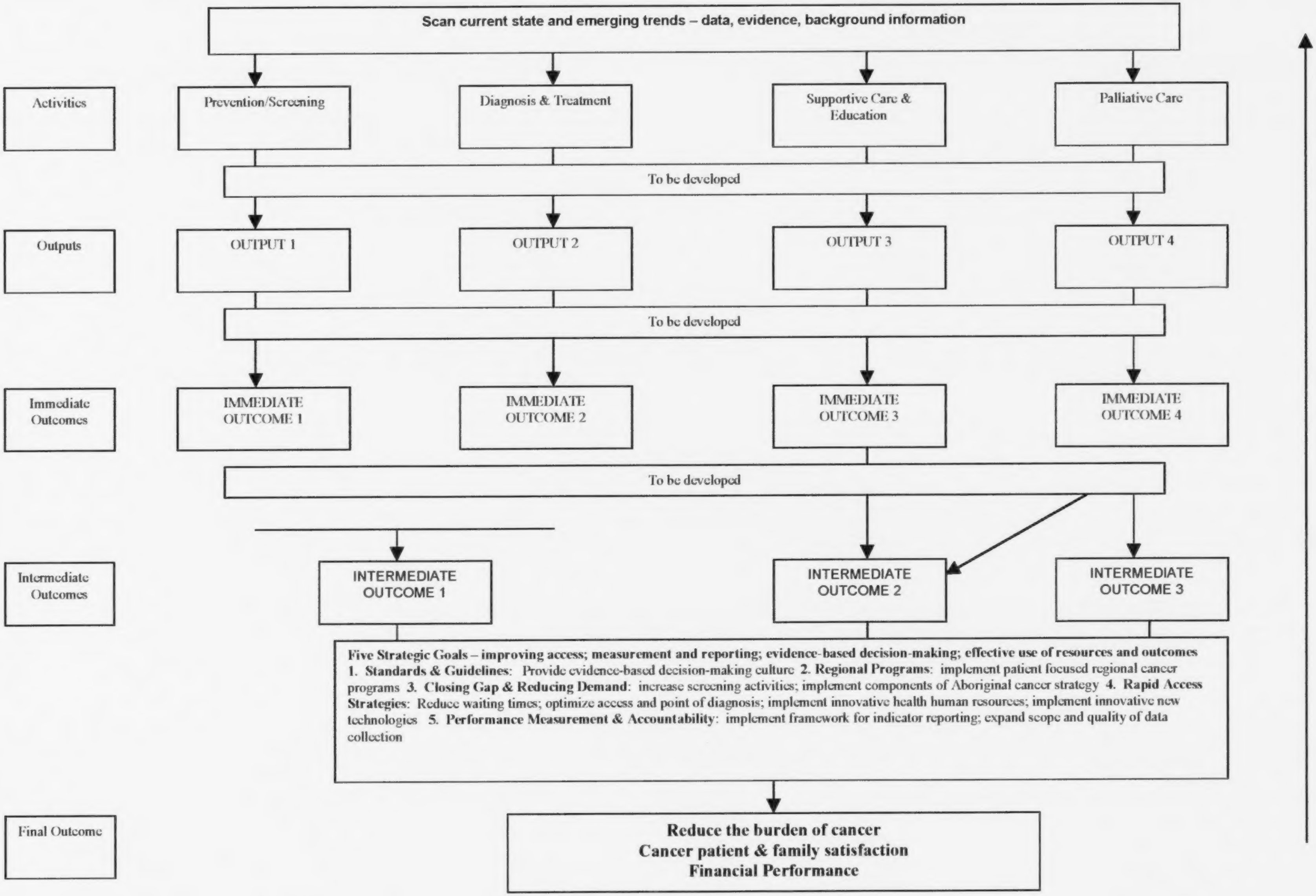
Opportunities to develop colorectal and cervical screening programs exist throughout the RCSA. However, without sizable investment progress in these areas, progress will continue to be slow and outcomes limited.

Transportation to and from care within and between counties, as well as a lack of family and specialist physicians currently and in the future, continues to be a "burning" issue in the region.

Since the 2004 regional plan, improvements in the areas of patient navigation through the Oncology Care Coordination Program need to be noted. Additionally, work to implement complex chemotherapy care closer to home has happened in Chatham Kent and sustaining program development at the Owen Sound site has occurred. The signing of an accountability agreement in February 2006, marked the bringing together of public health units, consumers, hospitals and hospital networks, Canadian Cancer Society, and Community Care Access Centres to improve the system of cancer care and prevention services is regarded as a landmark development for the region.

Based on an analysis of the all of the information collected, a number of strategic directions, performance indicators, and work plans were identified for the SW Regional Cancer Services Alliance. The RCSA Executive approved the revisions to the plan in July 2006.

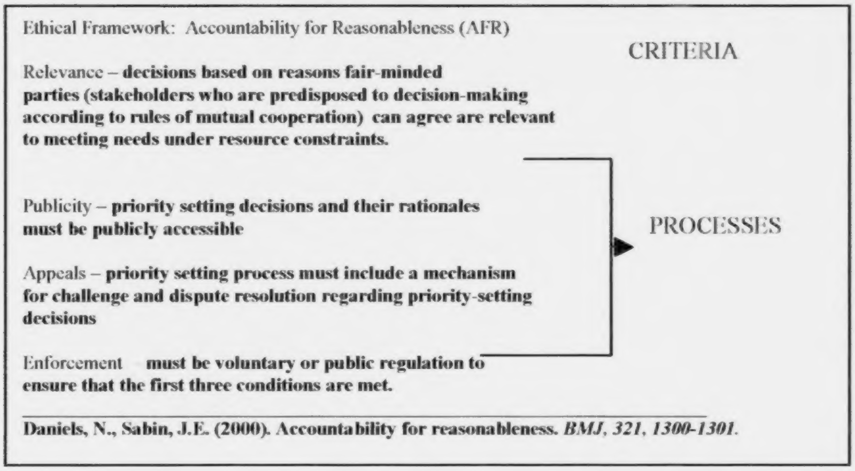
Appendix A - Logic Model Framework


Scan current state and emerging trends – data, evidence, background information
Activities
Prevention/Screening
Diagnosis & Treatment
Supportive Care & Education
Palliative Care
To be developed
Outputs
OUTPUT 1
OUTPUT 2
OUTPUT 3
OUTPUT 4
To be developed
Immediate Outcomes
IMMEDIATE OUTCOME 1
IMMEDIATE OUTCOME 2
IMMEDIATE OUTCOME 3
IMMEDIATE OUTCOME 4
To be developed
Intermediate Outcomes
INTERMEDIATE OUTCOME 1
INTERMEDIATE OUTCOME 2
INTERMEDIATE OUTCOME 3
Final Outcome

Five Strategic Goals – improving access; measurement and reporting; evidence-based decision-making; effective use of resources and outcomes
1. Standards & Guidelines: Provide evidence-based decision-making culture **2. Regional Programs**: implement patient focused regional cancer programs **3. Closing Gap & Reducing Demand**: increase screening activities; implement components of Aboriginal cancer strategy **4. Rapid Access Strategies**: Reduce waiting times; optimize access and point of diagnosis; implement innovative health human resources; implement innovative new technologies **5. Performance Measurement & Accountability**: implement framework for indicator reporting; expand scope and quality of data collection

Reduce the burden of cancer
Cancer patient & family satisfaction
Financial Performance

Appendix B - Accountability for Reasonableness



Ethical Framework: Accountability for Reasonableness (AFR)

CRITERIA

Relevance – **decisions based on reasons fair-minded parties (stakeholders who are predisposed to decision-making according to rules of mutual cooperation) can agree are relevant to meeting needs under resource constraints.**

PROCESSES

Publicity – **priority setting decisions and their rationales must be publicly accessible**

Appeals – **priority setting process must include a mechanism for challenge and dispute resolution regarding priority-setting decisions**

Enforcement **must be voluntary or public regulation to ensure that the first three conditions are met.**

Daniels, N., Sabin, J.E. (2000). Accountability for reasonableness. ***BMJ, 321, 1300-1301.***

PRIORITY SETTING CRITERIA

The following questions are designed to facilitate the selection of priorities based on their fit with the system of cancer care.

1. STRATEGIC FIT
   Do activities advance strategic directions?

2. ALIGNMENT WITH EXTERNAL DIRECTIVES
   Do activities align with existing government mandates and legislated obligations?

3. ACADEMIC MANDATE (if applicable)
   Do activities play a role in educating future health care professionals; in establishing best practice standards/ generating new medical knowledge/developing technological innovation?

4. CLINICAL IMPACT
   Do activities address service volumes necessary to ensure clinical competence; evidence of effectiveness in health promotion and disease prevention; uniqueness of health service in the area and quality of service provided?

5. COMMUNITY NEEDS
   Do activities address the health service needs of patients in the catchment area – demand, utilization rates, waiting list – and account for the availability of other health service providers?

6. PARTNERSHIPS (EXTERNAL)
   Do activities reflect existing formal agreements and commitments with other organizations in coordinating delivery of health care services?

7. INTERDEPENDENCY (INTERNAL)
Do activities address coordination and collaboration between clinical services to enhance service quality and efficient use of institutional resources?

8. RESOURCE IMPLICATIONS
Do activities address mobilization and effective use of human and fiscal resources?

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1. Gibson, J., Martin, D., and Singer, P. (2004). Setting Priorities in health care organizations: criteria, processes, and parameters of success. ***BMC Health Services Research*, 4:25,**

2. Mitton, C. and Donaldson,C. (2004). Health Care Priority Setting: principles, practice and challenges. ***Cost Effectiveness and Resource Allocation*, 2:3,**

3. Martin, D., Shulman, K., Santiago-Sorrell, P. and Singer, P. (2003). Priority-setting and hospital strategic planning: a qualitative case study. ***Journal of Health Services Research and Policy*, 8:4, 197-201.**

SWOT ANALYSIS

APPENDIX J

ERIE ST. CLAIR SWOT ANALYSIS

APPENDIX J

Working together with the IHSP Steering Committee, the planning team embarked on creating a SWOT analysis for the Erie St. Clair LHIN.. This section attempts to first, list the findings under the four SWOT headings. Then, from this listing is taken the "weaknesses" and "threats" lists; with the assumption that it is the elements in these lists that are deemed to be the most likely factors that would expose Erie St. Clair's health system to risk.

These risk factors are further broken down in order to assist in identifying priority areas of attention. The intent in proposing risk management strategies is to also respect the eight broad themes of the overall Erie St. Clair Health Services Integrated Plan.

ERIE ST. CLAIR SWOT ANALYSIS

SWOT refers to the assessment of inherent Strengths, Weaknesses, Opportunities and Threats facing a particular sector, population or initiative. A SWOT analysis may be useful for prioritizing local issues or, later in the planning process to test or evaluate alternative strategies.*

* Roadmap to the Integrated Health Services Plan

Strengths

- Strong provincial economy in the short term with potential growth in technology area
- Consumer satisfaction for those getting service
- History of collaboration and partnerships amongst agencies including development of Networks
- Manageable population growth in Erie St. Clair
- Hospitals have been consolidated and generally are fiscally balanced
- Critical mass to support enhancement of selected Hospital services
- Existing clinical pathways and best practices in some areas
- Information management (IT) capacity in the system
- Wide spread interest in innovation and improvement within the health care system
- Dedicated volunteer base
- Diverse health care service delivery system
- Ontario Telemedicine
- Collaborative relationship with Academic Centres
- Satellite Medical School

Weaknesses

- Health Human Resource shortages, especially Doctors, Nurses, Therapists (Physio, O.T., Speech) and limited training capacity
- Unhealthy population in Erie St. Clair, relative to the Province
- Capacity issues in some sectors
- Public's ever increasing demand for services (expectations)
- Costs of new technology and drugs
- Fundraising capacity decreasing locally
- Expectation to do more work with fewer resources (quality of care issue)
- Professional staff burnout
- Ability to keep up with technology innovation/changes
- Consumer/family involvement in planning, decision-making and evaluation
- Responsiveness to diverse population needs
- Lack of an integrated infrastructure
- Information sharing capacity at the client level
- Ability to track/measure health care system performance
- Long waits and delays for some services
- Border security issues

Opportunities

- LHIN – improved system management/decision making
- Existing and new networks and collaboration (i.e. Canadian Institute for Health Information (CIHI) and Cardiac Care Network)
- Internet/information transfer
- Improved accountability
- "Stand Alone" Medical School
- MOH/LTC 10 Year Strategic Planning Framework
- Multi-year funding agreements (Hospitals, Community Health Centres, Community Care Access Centres, etc)
- MOH/LTC Transformation Agenda
- Increased accountability across the health system
- Reducing need for referral to services outside LHIN
- Joint staff training and development
- Shared support services (back office/other)
- Best practice advancement

- Educating the public
- Health promotion / prevention strategies
- Research advancement
- System wide planning
- Formal partnership development, including communication networks
- Comprehensive health human resources recruitment and retention strategies
- Collaborative initiatives between Ministries (i.e. Ministry of Health and Long Term Care and Ministry of Community and Social Services) and Industry
- Strength of industry's commitment to occupational health and safety for possible partnerships

Threats

- Aging population and greater percentage over age 65 than the Province
- Infectious diseases
- Increasing costs i.e. new technologies/new treatments
- Border issues: Border security affecting flow of trade and loss of human resources to US recruitment
- Acceleration of globalization
- Political processes (changes in political environment after an election, transition from regional offices to LHIN provincial model and re-organization of the Ministry of Health and Long Term Care)
- Increased competition for scarce resources
- Continued human resource shortages
- Shrinking workforce as population ages (smaller tax base)
- Donor saturation for fundraising
- Ability and capacity to manage data
- Government reporting requirements (time consuming)
- Public expectations of the health care system
- Slow pace to implement change in health system
- Expectations created by U.S. health care
- Rising drug costs
- Organizations capacity to deal with amount of change e.g. Provincial transformation agenda, LHIN expectations, Community and Internal expectations

Risk Identification, Mitigation & Management

The Erie St. Clair SWOT analysis revealed thirty-three risks (sixteen weaknesses and seventeen threats) inherent to the Erie St. Clair health system. To provide context to these risks, and to begin to identify mitigation strategies in order to minimize the risks, it is helpful to categorize them. This IHSP categorizes the risks within a local, provincial and global framework as outlined in Table 1.

Risk Management Categories within the Erie St. Clair LHIN

Factors	Weaknesses	Threats
Local	7	2
Provincial	6	7
Global	3	8
Total	16	17

Table 1: Risk management categories

The thirty-three risks are placed into further groupings in Table 2, 3, and 4, along with a brief reference to potential mitigation strategies/initiatives associated with reducing the risk. This categorization also suggests where emphasis could be placed in pursuing mitigation initiatives. In other words priority can be placed on local risks if one assumes that LHINs have a greater potential of influencing local issues than they have of impacting global or even provincial issues.

Local Risk Management Strategies or Erie St. Clair

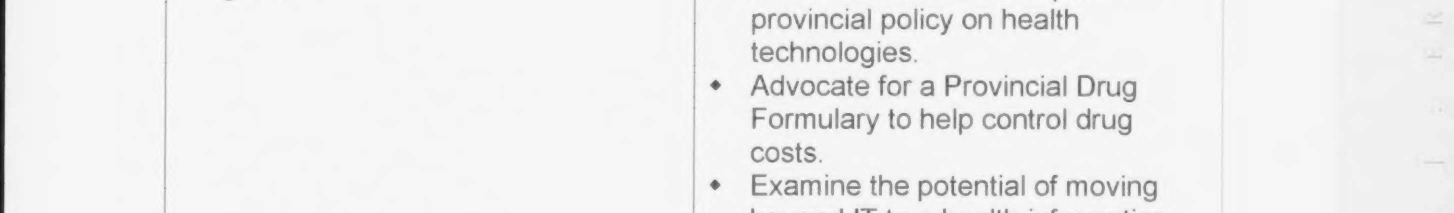
Local Risks	Potential Mitigation Strategies
Health Status: Greater proportion of population (compared with the province) over the age of 65: unhealthy population indicators relative to the province. Weak consumer/family involvement in planning, decision-making and evaluation.	◆ Develop a broader LHIN-wide health promotion strategy. ◆ Seek a list of potential strategies from ESC providers. ◆ Meet with public heath to consider strategies for healthy living. ◆ Identify opportunities for building public awareness.
Fiscal Limitations: Donor saturation & decreasing capacity.	◆ Identify the factors contributing to decreasing donor capacity. ◆ Help publicize the ministry's new capital funding policy for hospitals.

System performance: Lack of an integrated infrastructure; information sharing capacity at the client level; capacity Issues in some sectors; long waits and delays for some services.	◆ Develop a system navigation framework ◆ Identify joint support positions that cut across sectors. ◆ Emphasize "home based" needs of seniors, mental health and rural. ◆ Examine opportunities for information sharing utilizing the provisions of PHIPA privacy legislation. ◆ Promote and publicize the provincial wait list web site. ◆ Facilitate a primary care conference ◆ Develop a family health team/community health centre network.
Human Resources	◆ Identify the LHIN role with health human resource initiatives ◆ Create an ESC LHIN human resource profile and projected needs assessment ◆ Identify the integration needs of the volunteer sector.
Technology: Technology, in its various forms, is presenting new and escalating challenges.	• Promote cost/case analysis & economies of scale opportunities. • Propose an Erie St. Clair wide "Technology Management" working group. • Align with the provincial e-Health initiative.

Table 2: Local Risk Management Strategies

Provincial Risk Management Strategies for Erie St. Clair

Provincial Risks	Potential Mitigation Strategies
Political Factors: Change in political environment after an election; time consuming regulatory reporting requirements, transition from regional offices to LHIN, re-organization of the Ministry of Health and Long Term Care	◆ Keep the provincial political parties informed of the LHIN's progress and challenges ◆ Work with the Ministry of Health and Long Term Care (MoH/LTC) corporate office and the MoH/LTC regional offices to develop detailed strategies to transition to the LHIN staff without loss of knowledge and information and with a seamless transition of tasks and responsibilities to the appropriate parties.
Economic Pressures: Shrinking proportion of workforce as population ages = smaller tax base,	◆ Recognize that health services is a significant partner in the overall economic development of Erie St. Clair.
Technology: Ability and capacity to manage data. New technology and drug costs.	◆ Stay informed about the provincial e-health strategy. ◆ Advocate for the development of provincial policy on health technologies. ◆ Advocate for a Provincial Drug Formulary to help control drug costs. ◆ Examine the potential of moving beyond IT to a health informatics strategy



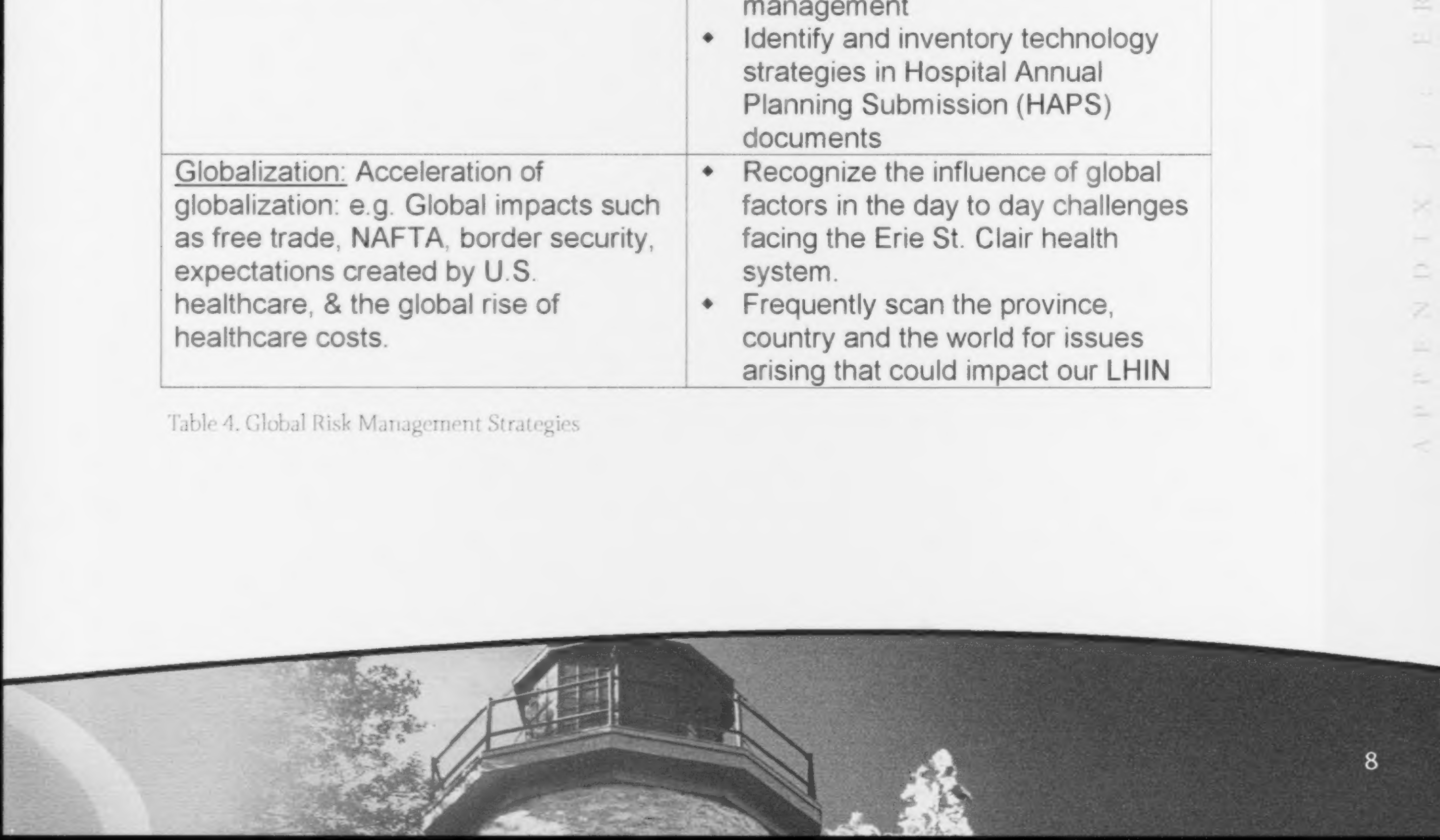
System Performance: Rising public expectations of the health system; responsiveness to diverse population needs; ability to track & measure system performance.	◆ Participate with other LHINs in identifying measures of performance. ◆ Contribute to the Ministry of Health and Long Term Care's strategic plan. ◆ Facilitate the development of a provincial chronic disease management strategy. ◆ Participate in review of hospital utilization in mental health and Alternate level of Care areas. ◆ Identify diverse population needs and develop strategies with providers to meet these needs ◆ Identify public perceptions and create a communication strategy
Human Resources: Doing more with less; professional staff burnout; organizational capacity to deal with amount & intensity of change (such as. transformation agenda, LHINs, community expectations, internal expectations).	◆ Request provincial bodies to examine the opportunities to widen the scope of health professions' roles.

Table 3: Provincial Risk Management Strategies

Global Risk Management Strategies for Erie St. Clair

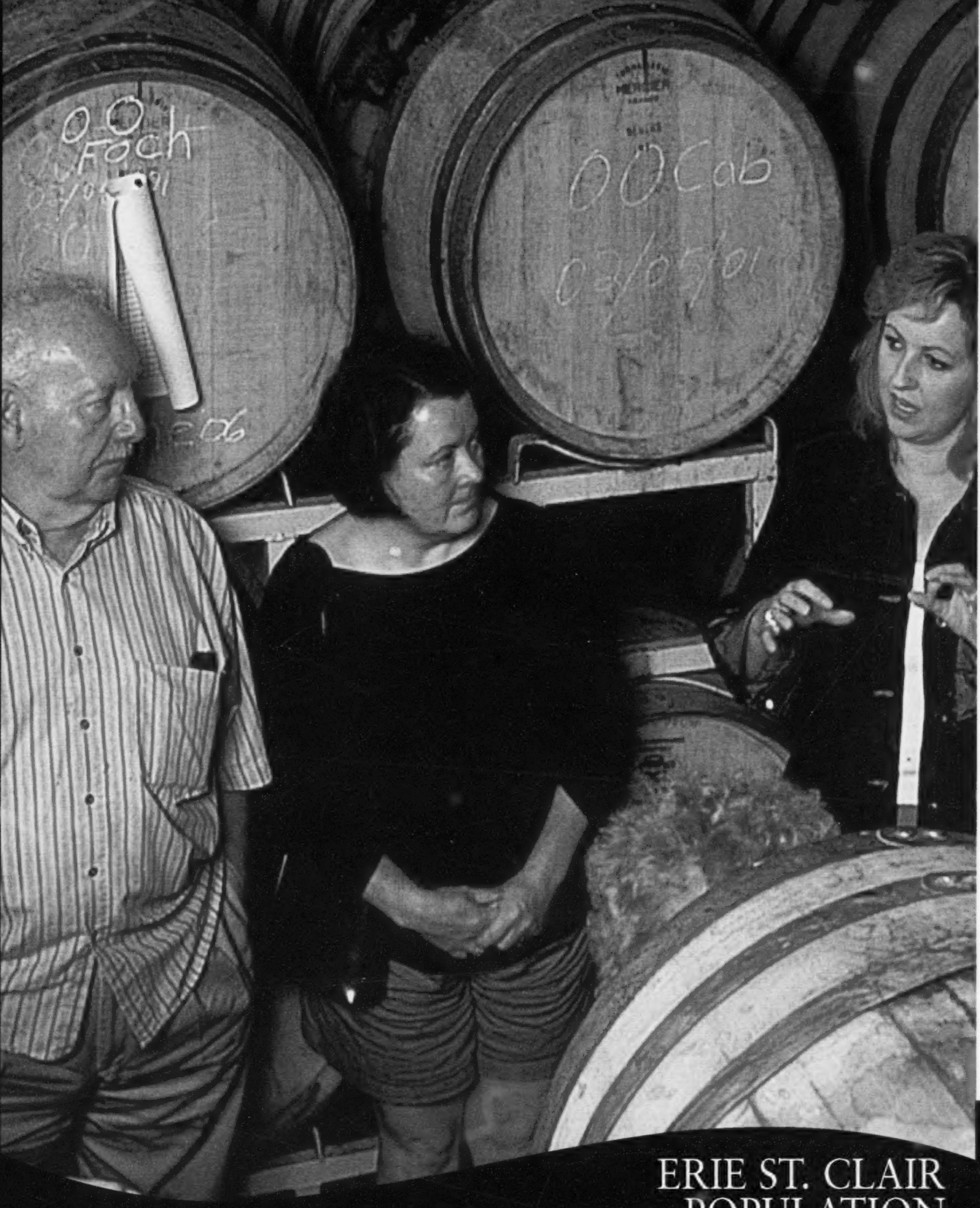
Global Risks	Potential Mitigation Strategies
Health Status: Disease outbreaks: SARS outbreak, pandemic flu, natural disasters, security, etc.	◆ Promote harmonization of provider emergency planning policies within the LHIN and identify the role of the LHIN ◆ Support Public Health emergency planning processes ◆ Participate with neighbouring LHINs and the ministry to maintain alignment with provincial requirements
Human Resources: Human resource shortages: especially the professions, competition for scarce resources, limited training capacity.	◆ Support integrated recruitment and retention of professional staff ◆ Initiate an Inventory of the health professions in the Erie St. Clair area and forecast future needs
Technology: The broad challenge of managing technology: i.e. introduction of new devices, cost of new drugs, keeping up with technology innovation, sustainable telemedicine; etc.	◆ Support including technology implementation requirements with technology assessments. ◆ Call for a more comprehensive approach to technology management ◆ Identify and inventory technology strategies in Hospital Annual Planning Submission (HAPS) documents
Globalization: Acceleration of globalization: e.g. Global impacts such as free trade, NAFTA, border security, expectations created by U.S. healthcare, & the global rise of healthcare costs.	◆ Recognize the influence of global factors in the day to day challenges facing the Erie St. Clair health system. ◆ Frequently scan the province, country and the world for issues arising that could impact our LHIN

Table 4. Global Risk Management Strategies



Summary

This healthcare SWOT analysis is a component of an overall environmental scan for the Erie St. Clair area at this point in time. Its impact will be strengthened in future scans when longitudinal information is prepared. Future risk analysis will be strengthened as local data is collected and more precise measurement instruments are brought into the analytical process.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ERIE ST. CLAIR POPULATION HEALTH PROFILE

APPENDIX K

ERIE ST. CLAIR POPULATION HEALTH PROFILE

APPENDIX K

Population Health Profile: Erie St. Clair LHIN

Health System Intelligence Project (HSIP) HSIP-PHP-01

Produced by HSIP for the Local Health Integration Networks (LHINs). HSIP is an independent, credible source of information and an initiative of the Health Results Team for Information Management (HRT-IM).

Executive Summary: This report provides an overview of the Erie St. Clair LHIN using the most recently available data on social and demographic characteristics, health status, health practices and outcomes of the population. Rates or proportions for Ontario are provided as a comparator.

Relative to the province, Erie St. Clair has a higher
- proportion of seniors
- prevalence of people who are overweight or obese
- prevalence of arthritis/rheumatism
- all-cause mortality, PYLL and hospitalization rates

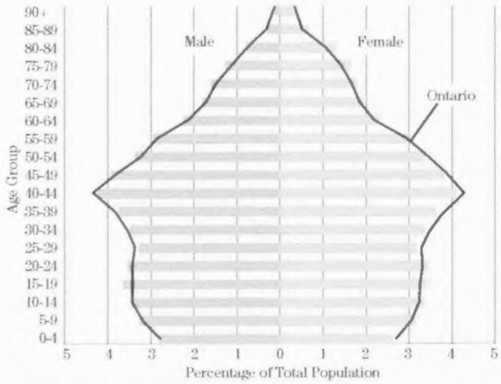
and a lower
- proportion of immigrants, visible minorities and adults with post-secondary credentials
- life expectancy for males and females
- proportion of the population consuming fruits and vegetables five or more times per day
- proportion of adults reporting a lot of life stress
- proportion of the population who say their health is Very Good or Excellent

The Erie St. Clair LHIN is an area of relatively slow population growth, with a high proportion of seniors. The population has a higher prevalence of some unhealthy behaviours and, compared to Ontario, residents are less likely to have positive assessment of their health.

The Population: Erie St. Clair is home to 645,200 people; 5.2% of the population of Ontario. During the 1994-2004 time period the population of Erie St. Clair increased, on average, by 0.8% each year. The population of Ontario increased by 1.5% annually during this same time. Table 1 provides an overview of the social and demographic characteristics of this population. Compared to the provincial average, Erie St. Clair has a greater proportion of seniors and a much smaller proportion of immigrants and visible minorities. Almost 4% of the population is Francophone (i.e., claim French as their mother tongue). The unemployment rate in Erie St. Clair is slightly higher than the provincial rate and relative to the province a smaller proportion of the Erie St. Clair population is in low income. Forty-three percent of adults (age 20+) have attained post-secondary education credentials, and 28.2% have not completed high school.

Chart 1 shows the population structure of Erie St. Clair. The black line provides the Ontario population distribution for comparison. The population pyramid shows that the population structure of the Erie St. Clair area is similar to Ontario's, with a somewhat higher proportion of the population in the elderly age groups, and a lower proportion in the 25-39 age groups.

Chart 2: Health practices, population age 12+



Data Source: 2004 Population estimates, Statistics Canada

Ontario

Table 1: Socio-demographic characteristics

	ERIE ST. CLAIR	ONTARIO	LHIN Range
Total population (2004)†	**645,200**	**12,392,700**	**242,500 - 1,542,900**
Senior population, age 65+ (2004)†	13.6%	12.8%	9.4 - 15.7%
Population with English mother tongue	80.0%	71.9%	55.7 - 92.2%
Population with French mother tongue	3.9%	4.7%	1.2 - 25.1%
Population who are immigrants	17.3%	26.8%	6.4 - 45.7%
Population who are recent immigrants (arrived between 1996-2001)	2.9%	4.8%	0.3 - 9.7%
Population who are visible minorities	8.1%	19.1%	1.3 - 38.8%
Population of Aboriginal identity	2.0%	1.7%	0.3 - 13.9%
Labour force participation rate (age 15+)	65.7%	67.3%	60.0 - 72.0%
Unemployment rate (age 15+)	6.5%	6.1%	5.0 - 9.8%
Population in low income	12.2%	14.4%	10.0 - 22.3%
Families (with children) headed by a lone parent	23.8%	23.4%	19.4 - 30.0%
Population (age 20+) with less than grade 9 education	9.5%	8.7%	6.3 - 12.0%
Population (age 20+) without high school graduation certificate	28.2%	25.7%	19.2 - 33.4%
Population (age 20+) with completed post-secondary education	43.0%	48.7%	42.4 - 55.8%

Data Source: †2004 Population estimates. Remaining indicators based on 2001 Census of Canada.

Health Status: Life expectancy at birth is the average years of life an individual could live on the assumption that current, cross-sectional age-specific mortality rates remain constant over the life span. Life expectancy among males and females in Erie St. Clair is significantly lower than life expectancy for Ontario overall (see Table 2). Low birthweight is an important determinant of infant morbidity and mortality. In Erie St. Clair 5.5% of infants born in 1999-2001 were of low birthweight. Infant mortality is a long-established measure, not only of child health, but also of the well-being of a society. The infant mortality rate in Erie St. Clair of 5.5 per 1000 livebirths is similar to the provincial experience. Self-reported health, an indicator of overall health status, can reflect aspects of health not captured in other measures, such as disease severity, aspects of positive health status, physiological and psychological reserves and social and mental function. Residents of Erie St. Clair are significantly less likely than Ontarians overall to rate their health as "Excellent" or "Very Good". One in four residents report being limited in their activities because of a physical or mental condition or health problem which has lasted or is expected to last longer than six months.

Table 2: Health status

	ERIE ST. CLAIR	ONTARIO	LHIN Range
Female life expectancy at birth (years), 2001†	81.2* (±0.5)	82.1 (±0.1)	79.5 - 82.2
Male life expectancy at birth (years), 2001†	76.2* (±0.5)	77.5 (±0.1)	74.7 - 80.6
Low birth weight babies (1999-2001)‡	5.5%	5.6%	3.7 - 6.2%
Infant mortality rate per 1000 livebirths (1999-2001)†‡	5.5 (±1.1)	5.4	3.9 - 6.1
Population who say their health is Excellent or Very Good, 2003 (age 12+)[#]	53.7%* (±2.5)	57.4% (±0.7)	51.0 - 61.5%
Population with an activity limitation, 2003 (age 12+)[#]	24.7% (±2.2)	24.6% (±0.6)	19.3 - 30.0%

** Significantly different from provincial average based on assessment of 95% confidence intervals.*
Data sources: † Ontario Vital Statistics, Mortality Database, ‡ Ontario Vital Statistics, Livebirths Database
[#] Canadian Community Health Survey, 2003

Table 3: Use of preventive care

	ERIE ST. CLAIR	ONTARIO	LHIN Range
Had mammogram in past 2 years (females age 50-69)	75.2% (±5.3)	70.6% (±1.9)	65.8 - 77.2%
Had Pap smear test in past 3 years (females age 18+)	65.4% (±3.3)	69.2% (±1.0)	65.4 - 75.5%
Had flu shot in past year (age 12+)	36.7% (±2.2)	34.2% (±0.7)	30.3 - 39.0%
Contact with Medical Doctor in past year (age 12+)	80.8% (±2.2)	81.4% (±0.6)	76.4 - 83.7%

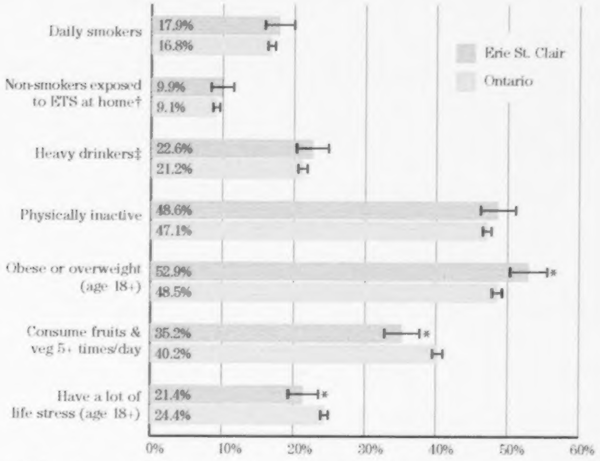
Data source: Canadian Community Health Survey, 2003

Health Practices and Preventive Care: Poor health practices are known to be related to increased risk of chronic disease, mortality and disability. Chart 2 shows that, relative to the province, those in Erie St. Clair are significantly more likely to be overweight/obese, and less likely to consume an adequate amount of fruits and vegetables. Based on Body Mass Index 35.9% of the adult population of Erie St. Clair is considered overweight and 17.0% are obese. Compared to the provincial average Erie St. Clair also has a slightly higher proportion of daily smokers, heavy drinkers, and inactive population but these differences are not statistically significant. However, Erie St. Clair residents are significantly less likely to report that they have a lot of life stress.

The use of preventive health care services can lead to early detection of disease, which ultimately results in reduced morbidity and mortality. Mammography and flu shot rates for Erie St. Clair are among the highest in the province, but the use of Pap smears (for cervical cancer screening) among women in Erie St. Clair is the lowest in the province (see Table 3). Early detection of cervical cancer improves chances of survival.

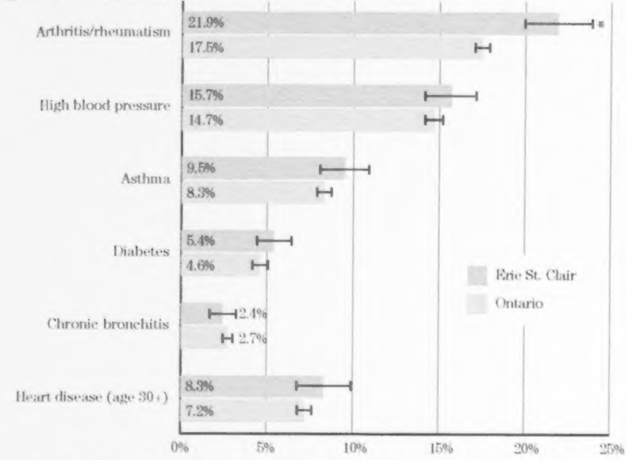
The point of access for most medical care is through a primary care physician. Medical doctors also play a key role in coordinating care and

Chart 2: Health practices, population age 12+



† ETS-environmental tobacco smoke (second-hand smoke)
‡ as a proportion of current drinkers
** Significantly different from provincial average based on assessment of 95% confidence interval.*
Data Source: Canadian Community Health Survey, 2003

Chart 3: Prevalence of selected chronic conditions, population age 12+



** Significantly different from provincial average based on assessment of 95% confidence interval.*
Data Source: Canadian Community Health Survey, 2003

managing chronic conditions. The majority of people (80.8%) in Erie St. Clair had at least one contact, either in person or by phone, with a medical doctor in the past year. This is similar to the Ontario average of 81.4%.

Morbidity and Mortality: Chronic conditions place a high burden on the health care system and reduce the quality of life of those who suffer from the condition. Chart 3 shows that, compared to Ontario, Erie St. Clair has a significantly higher prevalence of arthritis/rheumatism and slightly higher rates of other chronic conditions such asthma, diabetes, heart disease, and high blood pressure. Prevalence rates presented in Chart 3 are not age-standardized, and therefore areas with a high proportion of seniors will tend to have higher rates of chronic conditions.

Table 4: Mortality, PYLL and hospitalization rates by ICD-10 chapter

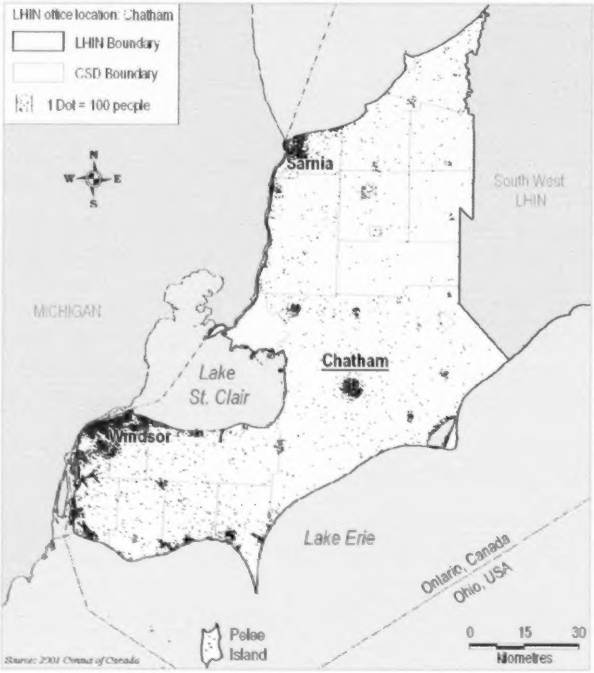
		Age-standardized mortality rate per 100,000 (avg. 2000-01)†		Potential Years of Life Lost rate per 100,000 (avg. 2000-01)†		Age-standardized hospitalization rate per 100,000 (2003-04)‡	
Cause (ICD-10 chapter)		ERIE ST. CLAIR	ONTARIO	ERIE ST. CLAIR	ONTARIO	ERIE ST. CLAIR	ONTARIO
ALL CAUSES		**657.2**	**602.6**	**5,424**	**4,864**	**8,959.3**	**7,746.7**
I.	Infectious diseases	6.1	9.3	81.3	122.3	107.2	119.9
II.	Neoplasms	194.0	181.4	1,763.9	1,590.3	636.8	549.6
III.	Diseases of blood	1.6	2.1	17.1	18.4	84.1	76.2
IV.	Endocrine/nutritional disorders	26.5	26.1	174.1	171.0	200.8	173.7
V.	Mental & behavioural disorders	15.3	15.0	72.9	59.2	648.0	502.7
VI.	Nervous system diseases	20.6	24.8	137.8	142.9	133.0	111.6
VII.	Eye diseases	0	-	0	-	22.4	20.1
VIII.	Ear diseases	0	-	0	1.1	31.5	20.7
IX.	Circulatory system diseases	254.4	209.1	1,043.3	852.9	1,233.6	1,007.5
X.	Respiratory system diseases	44.7	45.4	221.3	150.5	727.1	624.6
XI.	Digestive system diseases	25.7	22.6	262.2	191.1	911.1	761.2
XII.	Skin diseases	1.3	1.0	3.8	3.9	73.8	65.9
XIII.	Musculoskeletal diseases	4.0	3.8	31.9	24.8	465.2	356.0
XIV.	Genitourinary diseases	9.8	11.1	46.8	38.2	572.6	421.0
XV.	Maternal conditions	-	0.1	6.3	4.6	1,326.8	1,367.8
XVI.	Perinatal conditions	2.3	4.2	145.0	266.5	85.9	71.7
XVII.	Congenital abnormalities	4.2	3.1	212.5	158.0	52.3	47.9
XVIII.	Symptoms not elsewhere classified	13.7	10.8	285.4	234.0	543.2	457.9
XIX.	Injury & poisoning	n/a	n/a	n/a	n/a	627.1	578.6
XX.	External causes of mortality	32.8	32.6	916.6	834.3	n/a	n/a
XXI.	Factors influencing use of services	n/a	n/a	n/a	n/a	476.6	408.6

- Data suppressed due to small numbers
Data sources: † Ontario Vital Statistics, Mortality Database ‡ Ontario Hospital Inpatient Database

Table 4 provides age-standardized mortality and hospitalization rates as well as rates for potential years of life lost (PYLL) by ICD-10 chapter. In Erie St. Clair 20.7% of deaths occur before the age of 65, and 41.0% occur before the age of 75 (the Ontario percentages are 21.3% and 41.2% respectively). All-cause mortality, PYLL and hospitalization rates in Erie St. Clair are higher than provincial rates. This appears to be due primarily to higher rates of circulatory disease, the leading cause of mortality and morbidity. PYLL rates are useful for quantifying the number of years of life "lost" from deaths that occur "prematurely" (i.e., before age 75). Table 4 shows that, in Erie St. Clair, neoplasms contribute to more years of potential life lost than any other cause, followed by circulatory system diseases, and external causes (i.e., injuries).

Map 1 shows the 2001 population distribution (mapped by dissemination areas) within the Erie St. Clair LHIN area. Census subdivision (CSD) boundaries (analogous to municipal boundaries in most areas) and the names of selected communities are shown for reference. One third of the Erie St. Clair population resides in the Windsor CSD (population of approximately 208,400), with Chatham-Kent (107,300) and Sarnia CSDs (70,900) following as the next most populous areas (18% and 12% of the population respectively). The remainder of Erie St. Clair is made up of CSDs ranging in population size from 260 people (Pelee Island) to approximately 29,000 (Lakeshore).

Map 1: Population distribution in Erie St. Clair



Source: 2001 Census of Canada

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Glossary

Age-standardization: adjustment for variations in population age distributions over time and place. Mortality and hospitalization rates are adjusted using the Direct Method and the 1991 Canadian population.

Body Mass Index (BMI): a measure of body weight adjusted for height which is correlated with body fat. BMI is defined as weight in kilograms divided by height in meters squared. A BMI of 30 or more is classified as obese.

Census subdivision: area that is a municipality or an area that is deemed to be equivalent to a municipality for statistical reporting purposes (e.g., as an Indian reserve or an unorganized territory). Municipal status is defined by laws in effect in each province and territory in Canada.

Confidence intervals: indicate the degree of variability associated with an estimate. A 95% confidence interval indicates that estimates are accurate within the upper and lower confidence interval 19 times out of 20. Upper and lower bounds are shown as ± values in tables and error bars in charts.

Dissemination areas (DAs): the smallest standard geographic area for which census data are disseminated. DAs are composed of one or more neighbouring blocks, with a population of 400 to 700 persons.

Hospitalization rate: refers to the hospital separation rate for all hospital inpatients excluding newborns and stillbirths. A separation may be due to death, discharge home, or transfer to another facility.

ICD-10: refers to the International Classification of Diseases, 10th revision. The ICD is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and hospital records. ICD chapters are broad classifications which are subdivided into more specific conditions.

Potential Years of Life Lost: represents the number of years not lived by an individual from birth to age 75 due to premature death. The PYLL rate provides the total years of life lost before age 75 to the total population under 75.

Statistical significance: an inference that a result is unlikely to have occurred due to chance alone.

GLOSSARY OF TERMS USED IN THE IHSP

APPENDIX L

GLOSSARY OF TERMS

APPENDIX L

ASA – Age Standardized Rates : Summary rate that removes the effect of age from comparisons between populations by applying the age/gender specific rates for specific populations to a standard population structure. The rate reflects what the crude rate would be if all populations had the same age structure. The standard population for this report was the 1991 Canadian population.

ALC Alternate Level of Care: When a non acute treatment patient occupies an acute care bed, while awaiting placement in another program or facility.

ALOS (Average Length of Stay) – the average number of days of care for

ASIR – Age standardized incident rate

ASMR – Age standardized mortality rate an inpatient treatment episode.

Back office – part of most corporations where tasks dedicated to running the company itself take place. Examples of back office tasks include IT departments that keep the phones and computers running, accounting, and human resources. These tasks are often supported by back office systems such as secure e commerce software that processes company information (i.e. a database).

BMI – Body mass index

CCAC – Community Care Access Centre

CCHS – Canadian Community Health Survey

CEO Chief Executive Officer

CIHI – Canadian Institute for Health Information

CIW Canadian Index of Wellbeing

C-K Chatham – Kent

CLRD - Chronic lower respiratory disease

CMG - Case Mix Groups - categorization method defining the primary reason for acute care hospital use based on diagnoses and/or procedures provided. CMG is a trademark of CIHI.

CMHA - Canadian Mental Health Association

CNO - College of Nurses of Ontario

Confidence Interval (95% CI) The range of values around an estimate or rate, within which the true value for the population can be expected to fall. This interval shows the degree of variability in the estimate, where wide intervals reflect a higher degree of variability.

Conservable Days Hospital inpatient days that could have been avoided.

COPD - Chronic Obstructive Pulmonary Disease or CLRD - Chronic Lower Respiratory Disease - Category of respiratory diseases characterized by blockage or impairment of the alveoli, inhibiting the ability of the lungs to exchange oxygen and carbon dioxide. Included in this category are bronchitis, emphysema, asthma, bronchiectasis, allergic alveolitis and chronic airway obstruction.

CPRO - Client Profile Database

Crude Rate - Estimate of the proportion of a population effected by a condition during a specific period that has not been adjusted for the age/gender of the population. The numerator is the number of individuals effected and the denominator is the size of the population mid-year

CSS - Community Support Services

CT - Computed Tomography - uses a series of X-rays to create image "slices" (usually about one slice per millimetre) of a patient's body. When the images are stacked together by a computer, they can produce a 3-D image useful to diagnosing illness or planning radiation treatment. The wait time target (Priority 4) for CT (Computerized Tomography) is 28 days.

CTC - Children's Treatment Centre

DAD – Discharge Abstract Database – Collected from hospitals across Canada by the Canadian Institute of Health Information, provides a record of basic demographic, administrative and clinical data for hospital inpatient and day surgery services

DATIS – Drug and Alcohol Treatment Information System

Determinants of Health

1. Income and Social Status
2. Social Support Networks
3. Education and Literacy
4. Employment/Working Conditions
5. Social Environments
6. Physical Environments
7. Personal Health Practices and Coping Skills
8. Healthy Child Development
9. Biology and Genetic Endowment
10. Health Services
11. Gender
12. Culture

DFLE – Disability Free Life Expectancy

DST – Decision Support Team

Divestment Tier 1 – the process of transfer of governance and operations of a Provincial Psychiatric Hospital to a Public Hospital Board. Tier 2 – the subsequent process of transfer of psychiatric beds and associated services received by a Tier 1 receiving Public Hospital Board. Tier 3 – The process of transfer of former PPH programs and services to a community agency otherwise known as community reinvestment.

ED – Emergency department

eHealth – is a consumer-centered model of health care where stakeholders collaborate utilizing ICTs including Internet technologies to manage health, arrange, deliver, and account for care, and manage the health care system.

EKL – Essex Kent Lambton

ESC LHIN Abbreviation used to designate the Erie St. Clair Local Health Integrated Network.

Family Health Team – an interdisciplinary team of physicians and other providers such as nurse practitioners, nurses, social workers and dieticians all working together to see more patients and to keep them healthy.

FIM – Financial Information Management

FLS – French Language Service

GP – General Practitioner

HD – Heart Disease

HIT- Hospital Indicator Tool

Health Informatics – The discipline which develops and implements information tools, techniques and technologies to support population health clinical care, health services administration, research and teaching, including decision support and communication.

HSM – Abbreviation used to refer to previous Health System Monitoring reports.

HSRC (Health Services Restructuring Commission) – the agency responsible for setting directives for hospital restructuring (including bed numbers) in Ontario

ICD – International Classification of Disease

ICT – Information and Communications Technology, or technologies – is an umbrella term that includes any communication device or application, encompassing: radio, television, cellular phones, computer and network hardware and software, satellite systems and so on, as well as the various services and applications associated with them, such as videoconferencing and distance learning.

IHD – Ischaemic Heart Disease – refers to symptomatic narrowing of the coronary arteries resulting in inadequate flow to the heart muscle, including the diagnoses of acute myocardial infarction, angina pectoris and atherosclerosis.

IHSP – Integrated Health Service Plan

IMG – International Medical Graduate

IMU - Information Management Unit

Incidence Rate - number of new cases of disease in the population. The numerator is the number of new cases during a defined period divided by the total population at risk during the period.

IT - Information (Systems) Technology - The branch of engineering that deals with the use of computers and telecommunications to retrieve and store and transmit information

JPPC - Joint Policy & Planning Committee

Level of Care - Categorization of hospital care according to the degree of medical and/or technological specialization necessary to treat the case (primary, secondary, tertiary, or quaternary).

LHIN - Local Health Integration Network

LICO - Low Income Cut-Off, as defined by Statistics Canada

LTC - Long Term Care

MRI - Magnetic Resonance Imaging - high quality images of areas inside the body are generated by the use a strong magnetic field and radio waves. MRI is especially useful in imaging the brain, spine, the soft tissue of joints, and the inside of bones, abdomen and pelvis and can discover cancer and other diseases. The wait time target (Priority 4) for MRI (Magnetic Resonance Imaging) is 28 days.

Management of Technology - the planning, development and implementation of technological capabilities, for the purpose of attaining the strategic and operational goals of organizations.

MCSS - Ministry of Community and Social Services

MCYS - Ministry of Childrens and Youth Services

MNRH - May not require hospitalization.

MOHLTC - Ministry of Health and Long Term Care

NACRS - National Ambulatory Care Reporting System - collected from hospitals across Canada by the Canadian Institute for Health Information, provides a record of demographic, clinical and administrative data related to patient visits to hospital and community based ambulatory care - emergency visits and day procedures.

NP - Nurse Practitioner

OHIP - Ontario Health Insurance Plan

OT - Occupational Therapy

PA - Planning area: used in this document to define geographic areas within ESC LHIN, e.g. Chatham/Kent, Essex, and Lambton.

Patient Days - the total number of days spent in hospital by patients.

PCC (Program Cluster Category) - Each category is based on the CMG for a case and are used to identify the specific hospital program area responsible for care (obstetrics, cardiology, psychiatry etc) such that a CMG can only be assigned to one PCC.

PDST - Planning Decision Support Tool

PHPDP - Provincial Health Planning Database

PHU - Public Health Unit

Prevalence Rate - The total number of individuals who have a condition at a particular time divided by the total population at risk for the condition.

PT - Physiotherapy

PYLL (Potential Years of Life Lost) - the number of years not lived by an individual who dies prior to the average life expectancy.

Rate - Measure of the probability of occurrence of an event, calculated as the number of events divided by the population at risk

RCC - Regional Cancer Centre

RMWT (Recommended Maximum Waiting Time) - The estimated maximum recommended waiting period for bypass surgery counted from the date a patient is accepted for surgery; used by the Cardiac Care Network to monitor access to surgery based on the seriousness of the patient's condition.

RN(EC) – Registered Nurse Extended Class have advanced knowledge and decision making skills in health assessment, diagnosis, therapeutics (including pharmacological, complementary and counselling interventions), health care management and community development and planning.

RUGs – Resource Utilization Groups

Separation – a case treated in hospital resulting in a discharge, death, sign out or transfer to another facility, from any general or allied specialty hospital.

Sentinel Events – Incidents of unnecessary disease, disability or untimely deaths due to conditions that are preventable or for which there are effective treatments that should prevent disability or death. Increases in rates may signal that the quality of care or prevention efforts may need to be improved.

SEC – Socioeconomic Status

Shared Services – Shared Services are defined as the consolidation of common corporate administrative systems and functions among departments and agencies to improve efficiency, effectiveness and lower costs of service delivery.

Statistical Significance – An inference that a result is unlikely to have occurred due to chance alone.

SW LHIN – Southwest Local Health Integration Network

Systems Approach – an approach to analysis based on the belief that the component parts of a system will act differently when isolated from their environment. It includes viewing systems in a holistic manner. Systems thinking recognizes that all human activity systems are open systems, therefore, they are affected by the environment in which they exist. Systems thinking recognizes that in complex systems, events are separated by distance and time, therefore, small catalytic events can cause large changes in the system. Systems thinking acknowledges that a change in one area of a system can adversely affect another area of the system, thus, it promotes organizational communication at all levels in order to avoid the silo effect.

Technology – A process, technique, or methodology – embodied in a product design or in a manufacturing or service process – which transforms inputs of labour, capital, information, material and energy into outputs of greater value.

TTP – Time To Placement, in days

Wait Times - Refer to wait times for five key health services: cancer surgery, cardiac surgery, cataract surgery, hip & knee replacement and MRI and CT scans. These five areas are central to the Ontario government's wait time strategy.

WECB - Windsor Essex Community Branch

WHO - World Health Organization

WMS - Withdrawal Management Service